

July 27, 2017

Ms. Kathryn Olson
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street – 2nd Floor
Springfield, Illinois 62761

**RE: *Certificate of Exemption Application submittals
Long-Term Care Category of Service Discontinuation
Northwestern Medicine Lake Forest Hospital***

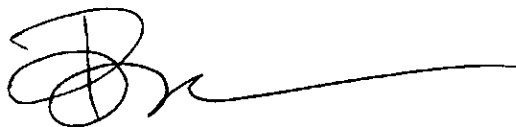
Dear Ms. Olson:

Enclosed are the following materials supporting Northwestern Medicine Lake Forest Hospital's Certificate of Exemption application for the discontinuation of the long-term care category of service:

- COE Permit Application (2 unbound copies, including original)
- COE Permit Application Fee - in the amount \$2,500

If you have any questions/comments, please feel to contact me at (312) 926-8650.

Sincerely,



Bridget S. Orth
Director, Regulatory Planning

enclosures

RECEIVED

JUL 28 2017

HEALTH FACILITIES &
SERVICES REVIEW BOARD

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

RECEIVED

This Section must be completed for all projects.

JUL 28 2017

Facility/Project Identification**HEALTH FACILITIES &
SERVICES REVIEW BOARD**

| | | | |
|--------------------|---|---------------------|------------------------------|
| Facility Name: | Northwestern Medicine Lake Forest Hospital - Long-Term Care Discontinuing | | |
| Street Address: | 660 North Westmoreland Road | | |
| City and Zip Code: | Lake Forest, IL 60045 | | |
| County: | Lake | Health Service Area | 8 Health Planning Area: A-09 |

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

| | |
|-------------------------------------|-------------------------------------|
| Exact Legal Name: | Northwestern Memorial HealthCare |
| Street Address: | 251 East Huron Street |
| City and Zip Code: | Chicago, IL 60611 |
| Name of Registered Agent: | Danae Prousis |
| Registered Agent Street Address: | 211 East Ontario Street, Suite 1800 |
| Registered Agent City and Zip Code: | Chicago, IL 60611 |
| Name of Chief Executive Officer: | Dean M. Harrison |
| CEO Street Address: | 251 East Huron Street |
| CEO City and Zip Code: | Chicago, IL 60611 |
| CEO Telephone Number: | 312-926-3007 |

Type of Ownership of Applicants

| | | |
|--|--|--------------------------------|
| <input checked="" type="checkbox"/> Non-profit Corporation | <input type="checkbox"/> Partnership | |
| <input type="checkbox"/> For-profit Corporation | <input type="checkbox"/> Governmental | |
| <input type="checkbox"/> Limited Liability Company | <input type="checkbox"/> Sole Proprietorship | <input type="checkbox"/> Other |

o Corporations and limited liability companies must provide an **Illinois certificate of good standing**.

o Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

| | |
|-------------------|-------------------------------------|
| Name: | Bridget Orth |
| Title: | Director, Regulatory Planning |
| Company Name: | Northwestern Memorial HealthCare |
| Address: | 211 East Ontario Street, Suite 1750 |
| Telephone Number: | 312-926-8650 |
| E-mail Address: | borth@nm.org |
| Fax Number: | 312-926-4545 |

Additional Contact [Person who is also authorized to discuss the application for exemption permit]

| | |
|---------------|----------------------------------|
| Name: | Rob Christie |
| Title: | Senior Vice President |
| Company Name: | Northwestern Memorial HealthCare |

| | |
|-------------------|-------------------------------------|
| Address: | 211 East Ontario Street, Suite 1750 |
| Telephone Number: | 312-926-7527 |
| E-mail Address: | rchristi@nm.org |
| Fax Number: | 312-926-4545 |

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD APPLICATION FOR EXEMPTION PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

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|--------------------|---|---------------------|------------------------------|
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| City and Zip Code: | Lake Forest, IL 60045 | | |
| County: | Lake | Health Service Area | 8 Health Planning Area: A-09 |

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

| | |
|-------------------------------------|-------------------------------------|
| Exact Legal Name: | Northwestern Lake Forest Hospital |
| Street Address: | 660 North Westmoreland Road |
| City and Zip Code: | Lake Forest, IL 60045 |
| Name of Registered Agent: | Danae Prousis |
| Registered Agent Street Address: | 211 East Ontario Street, Suite 1800 |
| Registered Agent City and Zip Code: | Chicago, IL 60611 |
| Name of Chief Executive Officer: | Thomas J. McAfee |
| CEO Street Address: | 660 North Westmoreland Road |
| CEO City and Zip Code: | Lake Forest, IL 60045 |
| CEO Telephone Number: | 847-535-6101 |

Type of Ownership of Applicants

| | | |
|--|--|--------------------------------|
| <input checked="" type="checkbox"/> Non-profit Corporation | <input type="checkbox"/> Partnership | |
| <input type="checkbox"/> For-profit Corporation | <input type="checkbox"/> Governmental | |
| <input type="checkbox"/> Limited Liability Company | <input type="checkbox"/> Sole Proprietorship | <input type="checkbox"/> Other |

☐ Corporations and limited liability companies must provide an **Illinois certificate of good standing**.
☐ Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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| Address: | 211 East Ontario Street, Suite 1750 |
| Telephone Number: | 312-926-7527 |
| E-mail Address: | rchristi@nm.org |
| Fax Number: | 312-926-4545 |

Post Exemption Permit Contact

[Person to receive all correspondence subsequent to permit issuance-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960**]

| | |
|-------------------|--|
| Name: | Bridget Orth |
| Title: | Director, Regulatory Planning |
| Company Name: | Northwestern Memorial HealthCare |
| Address: | 211 East Ontario Street, Suite 1750, Chicago, IL 60611 |
| Telephone Number: | 312-926-8650 |
| E-mail Address: | borth@nm.org |
| Fax Number: | 312-926-4545 |

Site Ownership

[Provide this information for each applicable site]

| | |
|---|---|
| Exact Legal Name of Site Owner: | Northwestern Lake Forest Hospital |
| Address of Site Owner: | 660 North Westmoreland Road, Lake Forest, IL 60045 |
| Street Address or Legal Description of the Site: | Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease. |
| APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. | |

Operating Identity/Licensee

[Provide this information for each applicable facility and insert after this page.]

| | | | |
|--|--|--------------------------|--|
| Exact Legal Name: | Northwestern Lake Forest Hospital | | |
| Address: | 660 North Westmoreland Road, Lake Forest, IL 60045 | | |
| <input checked="" type="checkbox"/> | Non-profit Corporation | <input type="checkbox"/> | Partnership |
| <input type="checkbox"/> | For-profit Corporation | <input type="checkbox"/> | Governmental |
| <input type="checkbox"/> | Limited Liability Company | <input type="checkbox"/> | Sole Proprietorship <input type="checkbox"/> Other |
| <ul style="list-style-type: none"> ○ Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. ○ Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. ○ Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership. | | | |
| APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. | | | |

Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. **This map must be in a readable format.** In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 ([http:// www.illinois.gov/sites/hfsrb](http://www.illinois.gov/sites/hfsrb)).

APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT**1. Project Classification**

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:

- ☐ Change of Ownership
- ☒ Discontinuation of an Existing Health Care Facility or of a category of service
- ☐ Establishment or expansion of a neonatal intensive care or beds

2. Narrative Description

In the space below, provide a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does **NOT** have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

Northwestern Medicine Lake Forest Hospital (LFH) is requesting to discontinue its long-term care (LTC) category of service. LFH is currently authorized for 84 LTC beds which are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road, Lake Forest. The discontinuation will be effective at the time of HFSRB approval.

The project is classified as substantive because it proposes the discontinuation of an IDPH-designated category of service.

There are no project costs associated with this project.

Project Costs and Sources of Funds (Neonatal Intensive Care Services only)

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

| Project Costs and Sources of Funds | | | |
|---|----------|-------------|-------|
| USE OF FUNDS | CLINICAL | NONCLINICAL | TOTAL |
| Preplanning Costs | \$ 0 | \$ 0 | \$ 0 |
| Site Survey and Soil Investigation | \$ 0 | \$ 0 | \$ 0 |
| Site Preparation | \$ 0 | \$ 0 | \$ 0 |
| Off Site Work | \$ 0 | \$ 0 | \$ 0 |
| New Construction Contracts | \$ 0 | \$ 0 | \$ 0 |
| Modernization Contracts | \$ 0 | \$ 0 | \$ 0 |
| Contingencies | \$ 0 | \$ 0 | \$ 0 |
| Architectural/Engineering Fees | \$ 0 | \$ 0 | \$ 0 |
| Consulting and Other Fees | \$ 0 | \$ 0 | \$ 0 |
| Movable or Other Equipment (not in construction contracts) | \$ 0 | \$ 0 | \$ 0 |
| Bond Issuance Expense (project related) | \$ 0 | \$ 0 | \$ 0 |
| Net Interest Expense During Construction (project related) | \$ 0 | \$ 0 | \$ 0 |
| Fair Market Value of Leased Space or Equipment | \$ 0 | \$ 0 | \$ 0 |
| Other Costs To Be Capitalized | \$ 0 | \$ 0 | \$ 0 |
| Acquisition of Building or Other Property (excluding land) | \$ 0 | \$ 0 | \$ 0 |
| TOTAL USES OF FUNDS | \$ 0 | \$ 0 | \$ 0 |
| SOURCE OF FUNDS | CLINICAL | NONCLINICAL | TOTAL |
| Cash and Securities | \$ 0 | \$ 0 | \$ 0 |
| Pledges | \$ 0 | \$ 0 | \$ 0 |
| Gifts and Bequests | \$ 0 | \$ 0 | \$ 0 |
| Bond Issues (project related) | \$ 0 | \$ 0 | \$ 0 |
| Mortgages | \$ 0 | \$ 0 | \$ 0 |
| Leases (fair market value) | \$ 0 | \$ 0 | \$ 0 |
| Governmental Appropriations | \$ 0 | \$ 0 | \$ 0 |
| Grants | \$ 0 | \$ 0 | \$ 0 |
| Other Funds and Sources | \$ 0 | \$ 0 | \$ 0 |
| TOTAL SOURCES OF FUNDS | \$ 0 | \$ 0 | \$ 0 |
| NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. | | | |

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

| |
|---|
| Land acquisition is related to project <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Purchase Price: \$ <u>n/a</u> Fair Market Value: \$ <u>n/a</u> |
| The project involves the establishment of a new facility or a new category of service <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| If yes, provide the dollar amount of all non-capitalized operating start-up costs (including operating deficits through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100. Estimated start-up costs and operating deficit cost is \$ <u>n/a</u> . |

Project Status and Completion Schedules

| |
|---|
| For facilities in which prior permits have been issued please provide the permit numbers. |
| Indicate the stage of the project's architectural drawings: <div style="display: flex; justify-content: space-around;"> <input checked="" type="checkbox"/> None or not applicable <input type="checkbox"/> Preliminary </div> <div style="display: flex; justify-content: space-around;"> <input type="checkbox"/> Schematics <input type="checkbox"/> Final Working </div> |
| Anticipated project completion date (refer to Part 1130.140): <u>upon HFSRB approval</u> |
| Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140): <div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed. <input type="checkbox"/> </div> Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies <input type="checkbox"/> Financial Commitment will occur after permit issuance. |
| APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. |

State Agency Submittals [Section 1130.620(c)]

| |
|---|
| Are the following submittals up to date as applicable: <input checked="" type="checkbox"/> Cancer Registry <input checked="" type="checkbox"/> APORS <input checked="" type="checkbox"/> All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted <input checked="" type="checkbox"/> All reports regarding outstanding permits Failure to be up to date with these requirements will result in the application for permit being deemed incomplete. |
|---|

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

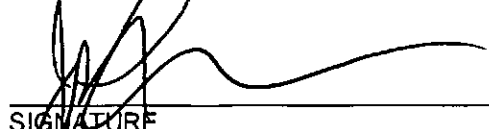
- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of Northwestern Memorial HealthCare *
in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.


SIGNATURE

Dean M. Harrison
PRINTED NAME

President and CEO
PRINTED TITLE

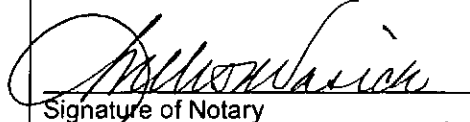

SIGNATURE

John A. Orsini
PRINTED NAME

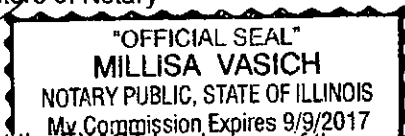
Senior Vice President and CFO
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 21st day of July


Signature of Notary

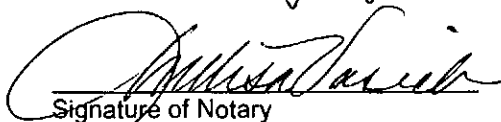
Seal



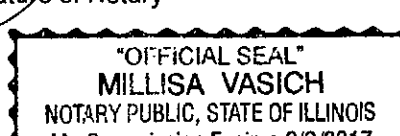
*Insert the EXACT legal name of the applicant

Notarization:

Subscribed and sworn to before me
this 21st day of July


Signature of Notary

Seal



CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of Northwestern Lake Forest Hospital *
in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

Thomas J. McAfee
PRINTED NAME

President
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 19 day of July, 2017

Signature of Notary

Seal

OFFICIAL SEAL
REGINA RIZZO
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES: 09/10/18

*Insert the EXACT legal name of the applicant

SIGNATURE

Richard A. Franco
PRINTED NAME

Chief Financial Officer
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 19 day of July, 2017

Signature of Notary

Seal

OFFICIAL SEAL
REGINA RIZZO
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES: 09/10/18

SECTION II. DISCONTINUATION

This Section is applicable to the discontinuation of a health care facility maintained by a State agency. **NOTE:** If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

Type of Discontinuation

- | | |
|-------------------------------------|---|
| <input type="checkbox"/> | Discontinuation of an Existing Health Care Facility |
| <input checked="" type="checkbox"/> | Discontinuation of a category of service |

Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any, that are to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, provide certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.
7. Upon a finding that an application to close a health care facility is complete, the State Board shall publish a legal notice on 3 consecutive days in a newspaper of general circulation in the area or community to be affected and afford the public an opportunity to request a hearing. If the application is for a facility located in a Metropolitan Statistical Area, an additional legal notice shall be published in a newspaper of limited circulation, if one exists, in the area in which the facility is located. If the newspaper of limited circulation is published on a daily basis, the additional legal notice shall be published on 3 consecutive days. The legal notice shall also be posted on the Health Facilities and Services Review Board's web site and sent to the State Representative and State Senator of the district in which the health care facility is located. In addition, the health care facility shall provide notice of closure to the local media that the health care facility would routinely notify about facility events.
8. Provide attestation that the facility provided the required notice of the facility or category of service closure to local media that the health care facility would routinely notify about facility events. The supporting documentation shall include a copy of the notice, the name of the local media outlet, the

date the notice was given, and the result of the notice, e.g., number of times broadcasted, written, or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.

REASONS FOR DISCONTINUATION

The applicant shall state the reasons for the discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.130(b) for examples.

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility and whether or not it will have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.

APPEND DOCUMENTATION AS ATTACHMENT 10, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

VI. 1120.120 - AVAILABILITY OF FUNDS (Neonatal Intensive Care Services only)

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable **[Indicate the dollar amount to be provided from the following sources]:**

| | |
|-----|---|
| n/a | a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: |
| | 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and |
| | 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion; |
| n/a | b) Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience. |
| n/a | c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts; |
| n/a | d) Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: |
| | 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; |
| | 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; |
| | 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; |
| | 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; |
| | 5) For any option to lease, a copy of the option, including all terms and conditions. |
| n/a | e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent; |
| n/a | f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt; |
| n/a | g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project. |
| n/a | TOTAL FUNDS AVAILABLE |

APPEND DOCUMENTATION AS **ATTACHMENT 16**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VII. 1120.130 - FINANCIAL VIABILITY

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All of the projects capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

| | Historical 3 Years | | | Projected |
|---|-----------------------|--|--|-----------|
| Enter Historical and/or Projected Years: | | | | |
| Current Ratio | | | | |
| Net Margin Percentage | | | | |
| Percent Debt to Total Capitalization | | | | |
| Projected Debt Service Coverage | | | | |
| Days Cash on Hand | | | | |
| Cushion Ratio | | | | |

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

2. Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt

obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 18, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII. 1120.140 - ECONOMIC FEASIBILITY

This section is applicable to all projects subject to Part 1120.

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

- 1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
- 2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
 - A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
 - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

- 1) That the selected form of debt financing for the project will be at the lowest net cost available;
- 2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;
- 3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

| COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE | | | | | | | | | |
|---|-------------------------|------|--------------------------------|---|---------------------------------|---|----------------------|--------------------|--------------------------|
| Department (list below) | A | B | C | D | E | F | G | H | Total Cost (G + H) |
| | Cost/Square Foot New | Mod. | Gross Sq. Ft. New Circ.* | | Gross Sq. Ft. Mod. Circ.* | | Const. \$ (A x C) | Mod. \$ (B x E) | |
| | | | | | | | | | |
| Contingency | | | | | | | | | |
| TOTALS | | | | | | | | | |
| * Include the percentage (%) of space for circulation | | | | | | | | | |

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT 19, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. SAFETY NET IMPACT STATEMENT (DISCONTINUATION ONLY)

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE STATE-OWNED HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 40.

| Safety Net Information per PA 96-0031 | | | |
|---------------------------------------|------|------|------|
| CHARITY CARE | | | |
| Charity (# of patients) | Year | Year | Year |
| Inpatient | | | |
| Outpatient | | | |
| Total | | | |
| Charity (cost in dollars) | | | |
| Inpatient | | | |
| Outpatient | | | |
| Total | | | |
| MEDICAID | | | |
| Medicaid (# of patients) | Year | Year | Year |
| Inpatient | | | |
| Outpatient | | | |
| Total | | | |
| Medicaid (revenue) | | | |
| Inpatient | | | |
| Outpatient | | | |
| Total | | | |

APPEND DOCUMENTATION AS ATTACHMENT 20, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

Charity Care information **MUST** be furnished for **ALL** projects [1120.20(c)].

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care **must** be provided at cost.

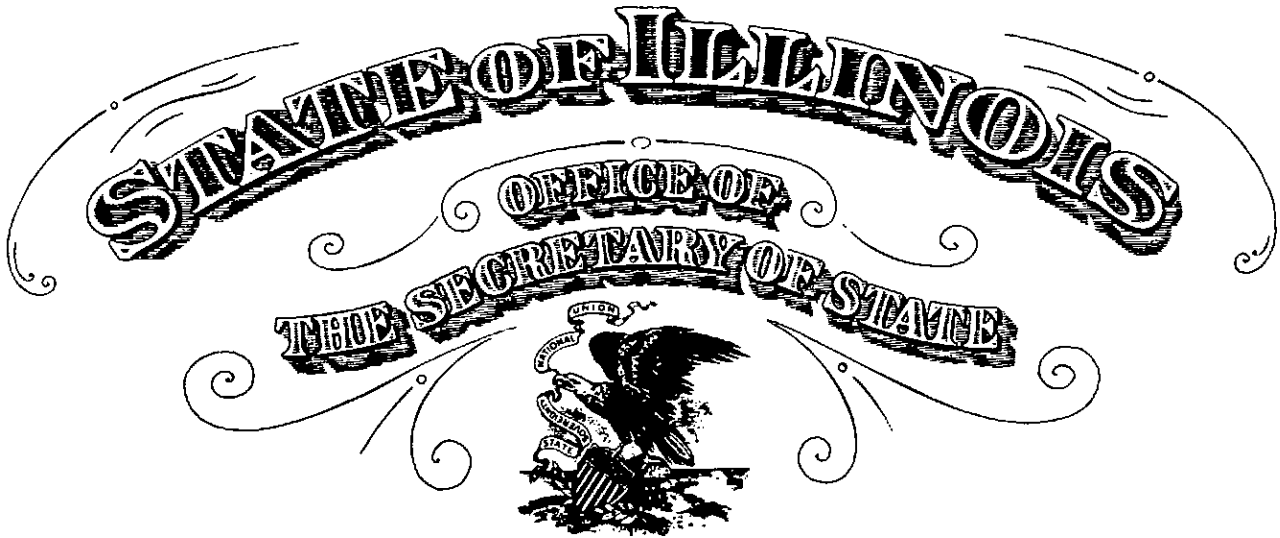
A table in the following format must be provided for all facilities as part of Attachment 41.

| CHARITY CARE | | | |
|----------------------------------|------|------|------|
| | Year | Year | Year |
| Net Patient Revenue | | | |
| Amount of Charity Care (charges) | | | |
| Cost of Charity Care | | | |

APPEND DOCUMENTATION AS **ATTACHMENT 21**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

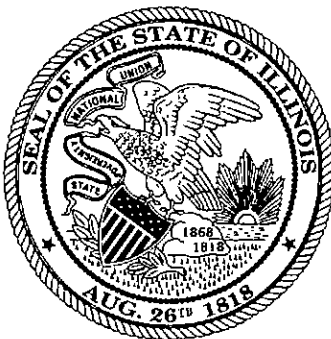
| INDEX OF ATTACHMENTS | | |
|----------------------|--|-------|
| ATTACHMENT NO. | | PAGES |
| 1 | Applicant Identification including Certificate of Good Standing | 21-22 |
| 2 | Site Ownership | 23-27 |
| 3 | Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership. | N/A |
| 4 | Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc. | 28 |
| 5 | Flood Plain Requirements | N/A |
| 6 | Historic Preservation Act Requirements | N/A |
| 7 | Project and Sources of Funds Itemization | N/A |
| 8 | Financial Commitment Document if required | N/A |
| 9 | Cost Space Requirements | N/A |
| 10 | Discontinuation | 29-93 |
| 11 | Background of the Applicant | N/A |
| 12 | Purpose of the Project | N/A |
| 13 | Alternatives to the Project | N/A |
| | Service Specific: | |
| 14 | Neonatal Intensive Care Services | N/A |
| 15 | Change of Ownership | N/A |
| | Financial and Economic Feasibility: | |
| 16 | Availability of Funds | N/A |
| 17 | Financial Waiver | N/A |
| 18 | Financial Viability | N/A |
| 19 | Economic Feasibility | N/A |
| 20 | Safety Net Impact Statement | 94-96 |
| 21 | Charity Care Information | 97 |



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

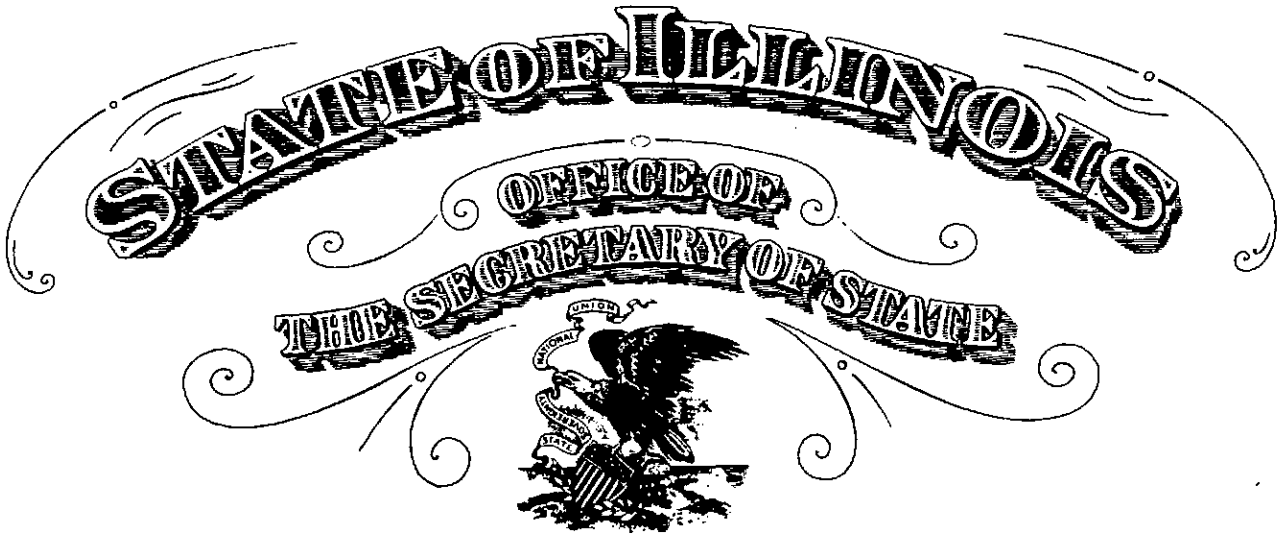
NORTHWESTERN MEMORIAL HEALTHCARE, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 30, 1981, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 20TH day of JULY A.D. 2017 .

Jesse White

SECRETARY OF STATE



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

NORTHWESTERN LAKE FOREST HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON DECEMBER 10, 1918, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 20TH day of JULY A.D. 2017 .

Jesse White

SECRETARY OF STATE

DEED-Statutory
(INDIVIDUAL TO CORPORATION)
Approved By Chicago Title and Trust Co.
(Chicago Real Estate Board)
S-3 1 of 2

1934994
1942003
1934994
(The Above Space For Recorder's Use Only)

410137 lake
THE GRANTOR— William J. Halligan, Jr. and Marydith Halligan,
his wife
of the City of Lake Forest County of Lake State of Illinois
for and in consideration of TEN and no/100----- (\$10.00) DOLLARS,
and other valuable consideration in hand paid,
CONVEY and WARRANT to Lake Forest Hospital, an Illinois corpora-
tion of Lake Forest, Illinois
a corporation created and existing under and by virtue of the Laws of the State of Illinois
having its principal office in the City of Lake Forest and
State of Illinois the following described Real Estate situated in the County
of Lake in the State of Illinois, to wit:
Exhibit A attached hereto and made a part hereof.

071558
STATE OF ILLINOIS
REAL ESTATE TRANSFER TAX
JUL 31 '78
DEPT. OF REVENUE
\$900.00
071557
STATE OF ILLINOIS
REAL ESTATE TRANSFER TAX
JUL 31 '78
DEPT. OF REVENUE
\$57.00
00758

Grantee's Address: Lake Forest Hospital, 660 Westmorland, Lake Forest
Illinois

hereby releasing and waiving all rights under and by virtue of the Homestead Exemption Laws of
the State of Illinois.

DATED this 30th day of June 1978

PLEASE PRINT OR TYPE NAME(S)
William J. Halligan, Jr. (Seal)
Marydith Halligan (Seal)
SIGNATURE(S)
Marydith Halligan

State of Illinois, County of Cook ss., I, the undersigned, a Notary Public in
and for said County, in the State aforesaid, DO HEREBY CERTIFY that
William J. Halligan, Jr. and Marydith Halligan,
his wife
personally known to me to be the same persons whose names are
subscribed to the foregoing instrument appeared before me this day in
person, and acknowledged that they signed, sealed and delivered the said
instrument as their free and voluntary act, for the uses and purposes
therein set forth, including the release and waiver of the right of homestead.

Given under my hand and official seal, this 14th day of July 1978
Commission expires 4/11 1979
THOMAS J. KELLY
NOTARY PUBLIC

Prepared by:
Thomas J. Kelly
Pedersen & Houpt
Suite 3400
NAME
ADDRESS 180 North LaSalle Street
CITY AND STATE Chicago, Illinois

ADDRESS OF PROPERTY:
THE ABOVE ADDRESS IS FOR STATISTICAL
PURPOSES ONLY AND IS NOT A PART OF
THIS DEED.
SEND SUBSEQUENT TAX BILLS TO:
CHICAGO TITLE INSURANCE CO.

1934994
DOC
LAKE COUNTY, ILLINOIS

'78 JUL 31 PM 2 43

Thomas J. Quast
RECORDER OF DEEDS

1942003
DOC
LAKE COUNTY, ILLINOIS

'78 AUG 29 AM 11 17

Thomas J. Quast
RECORDER OF DEEDS

Mail to ..

CHICAGO TITLE AND TRUST COMPANY

111 WEST WASHINGTON

CHICAGO, ILLINOIS 60602

ATTN: J. WERLE LL50

34313P

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

I, the undersigned, a Notary Public in and for said County, in the State aforesaid, DO HEREBY CERTIFY that William J. Halligan, Jr. and Marydith Halligan, his wife, personally known to me to be the same persons whose names are subscribed to the foregoing instrument appeared before me this day in person and acknowledged that they signed, sealed and delivered the said instrument as their free and voluntary act, for the uses and purposes therein set forth, including the release and waiver of the right of homestead.

Given under my hand and official seal, this 15th day of August, 1978.

1942003

My Commission Expires 6/24/80

PARCEL 1:

That part of the West half of Section 29, Township 44 North, Range 12, East of the 3rd P.M., described as follows: The South 18.79 acres lying South of a line drawn parallel with the South line of the West half of the South West quarter of said Section 29, (except that part thereof lying Easterly of the Westerly line of Skokie Highway, according to the plat of Dedication, therefore recorded as Document 418857, on November 18, 1935), in Lake County, Illinois.

PARCEL 2:

The West half of the South West quarter of Section 29, Township 44 North, Range 12, East of the 3rd P.M., (except that part thereof lying Easterly of the Westerly line of Skokie Highway, according to the plat of Dedication, therefore recorded as Document 418857, on November 18, 1935 and also except the South 18.79 acres thereof, lying South of a line parallel with the South line of said West half of the South West quarter), in Lake County, Illinois.

PARCEL 3:

That part of the North West quarter of Section 29, and the North East quarter of Section 30, all in Township 44 North, Range 12, East of the 3rd P.M., described as follows: Beginning at the South East corner of said North East quarter of Section 30; thence West along the South line of said North East quarter of Section 30, 1452.00 feet; thence North 13 degrees West 149.82 feet; thence East parallel with said South line of the North East quarter of Section 30, 1485.59 feet, more or less, to the East line of the North East quarter aforesaid; thence East parallel with the South line of said North West quarter of Section 29, 941.75 feet, more or less, to the Westerly line of Skokie Highway, according to the plat of Dedication therefore, recorded as Document 418857, on November 18, 1935; thence Southerly along said Westerly line of Skokie Highway 147.30 feet, more or less, to said South line of the North West quarter of Section 29, and thence, West along said South line of the North West quarter of Section 29, 960.60 feet, more or less, to the corner of beginning, in Lake County, Illinois.

1942003

PARCEL 4:

That part of the North half of the South East quarter of Section 30, Township 44 North, and Range 12, East of the 3rd P.M., lying Easterly of the Easterly line of the public highway known as Waukegan Road, except that part thereof described as follows: Beginning at a point on the Easterly line of the public highway known as Waukegan Road 341.00 feet Northerly of the South line of said North half of the South East quarter of Section 30, (measured along said Easterly line of Waukegan Road) and; thence, Northerly along said Easterly line of Waukegan Road 350.00 feet; thence Easterly along a line perpendicular to said Easterly line of Waukegan Road, 376.61 feet; thence Southerly parallel with said Easterly line of Waukegan Road, 350.00 feet; and thence Westerly along the line perpendicular to said Easterly line of Waukegan Road 376.61 feet to the place of beginning, in Lake County, Illinois.

THIS INSTRUMENT WAS PREPARED BY:

111 West Washington Street
Chicago, Illinois 60602



ER 0 Mail
RELEASE DEED

F. 1699 R. 12/73

Thomas Szymczyk
% Chicago Title and Trust Company
630-2168

2523020

2523020
RECORDED
LAKE COUNTY, ILLINOIS
1987 JAN -7 AM 9:12

THE ABOVE SPACE FOR RECORDERS USE ONLY

KNOW ALL MEN BY THESE PRESENTS, That CHICAGO TITLE AND TRUST COMPANY, a
corporation of the State of Illinois, as
Trustee

in consideration of one dollar, and other good and valuable considerations, the receipt whereof is hereby
acknowledged, does hereby release, convey and quit-claim unto

Lake Forest Hospital, not for profit.
the heirs, legal representatives and assigns of the grantee or grantees herein, (or if the grantee is a
corporation, its successors and assigns) all the right, title, interest, claim or demand whatsoever it may have
acquired in, through or by a certain Trust Deed, recorded in the Recorder's Office of
Lake County, in the State of Illinois, as Document Number 1934995

in book , page , to the premises situated in the said County, State of Illinois,
described as follows, to-wit:

PARCEL 1:

The West half of the South West quarter of Section 29, Town-
ship 44 North, Range 12, East of the 3rd P.M., (except that
part thereof lying Easterly of the Westerly line of Skokie
Highway, according to the plat of Dedication, therefore re-
corded as Document 418857, on November 18, 1935 and also
except the South 18.79 acres thereof, lying South of a line
parallel with the South line of said West half of the South
West quarter), in Lake County, Illinois.

PARCEL 2:

That part of the North West quarter of Section 29, and the
North East quarter of Section 30, all in Township 44 North,
Range 12, East of the 3rd P.M., described as follows: Beginning
at the South East corner of said North East quarter of Section
30; thence West along the South line of said North East quarter
of Section 30, 1452.00 feet; thence North 13 degrees West
149.82 feet; thence East parallel with said South line of the
North East quarter of Section 30, 1485.59 feet, more or less,
to the East line of the North East quarter aforesaid; thence
East parallel with the South line of said North West quarter
of Section 29, 941.75 feet, more or less, to the Westerly line
of Skokie Highway, according to the plat of Dedication therefore,
recorded as Document 418857, on November 18, 1935; thence
Southerly along said Westerly line of Skokie Highway 147.30
feet, more or less, to said South line of the North West
quarter of Section 29, and thence, West along said South line
of the North West quarter of Section 29, 960.60 feet, more or
less, to the corner of beginning, in Lake County, Illinois.

PARCEL 3:

2523020

That part of the North half of the South East quarter of Section
30, Township 44 North, and Range 12, East of the 3rd P.M., lying
Easterly of the Easterly line of the public highway known as
Waukegan Road, except that part thereof described as follows:
Beginning at a point on the Easterly line of the public highway
known as Waukegan Road 341.00 feet Northerly of the South line of
said North half of the South East quarter of Section 30, (measured
along said Easterly line of Waukegan Road) and; thence, Northerly
along said Easterly line of Waukegan Road 350.00 feet; thence
Easterly along a line perpendicular to said Easterly line of
Waukegan Road, 376.61 feet; thence Southerly parallel with said
Easterly line of Waukegan Road, 350.00 feet; and thence
Westerly along the line perpendicular to said Easterly line of
Waukegan Road 376.61 feet to the place of beginning, in Lake
County, Illinois.

26 CAGO TITLE INSURANCE CO

ATTACHMENT-2

THIS IN:

Thomas Szymczyk

Chicago Title and Trust Company

2523020

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together with all the appurtenances and privileges thereunto belonging or appertaining.

IN WITNESS WHEREOF, Said CHICAGO TITLE AND TRUST COMPANY, as Trustee as aforesaid, has caused these presents to be signed by its Assistant Vice-President, and attested by its Assistant Secretary, and its corporate seal to be hereto affixed.

(Date) December 30, 1986

CHICAGO TITLE AND TRUST COMPANY
as Trustee as aforesaid,



By

Alantha Smith

Assistant Vice-President

Attest

Joseph L. Masterson

Assistant Secretary

**FOR THE PROTECTION OF THE
OWNER, THIS RELEASE SHALL
BE FILED WITH THE RECORDER
OF DEEDS IN WHOSE OFFICE
THE MORTGAGE OR DEED OF
TRUST WAS FILED.**

STATE OF ILLINOIS, } ss.
COUNTY OF COOK

I, the undersigned, a Notary Public in and for the County and State aforesaid, DO HEREBY CERTIFY, that the above named Assistant Vice President and Assistant Secretary of the CHICAGO TITLE AND TRUST COMPANY, Grantor, personally known to me to be the same persons whose names are subscribed to the foregoing instrument as such Assistant Vice President and Assistant Secretary respectively, appeared before me this day in person and acknowledged that they signed and delivered the said instrument as their own free and voluntary act and as the free and voluntary act of said Company for the uses and purposes therein set forth; and the said Assistant Secretary then and there acknowledged that said Assistant Secretary, as custodian of the corporate seal of said Company, caused the corporate seal of said Company to be affixed to said instrument as said Assistant Secretary's own free and voluntary act and as the free and voluntary act of said Company for the uses and purposes therein set forth.

Given under my hand and Notarial Seal

Date 12/30/86

Diane Helms

Notary Public

D
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L
I
V
E
R
Y
INSTRUCTIONS

NAME
Wilson & McIlvaine
ATTN: B. Adler
135 S. La Salle Street
CITY Chicago, Il 60603

OR

CHICAGO
27

FOR INFORMATION ONLY
INSERT STREET ADDRESS OF ABOVE
DESCRIBED PROPERTY HERE



ATTACHMENT 2

SECTION II. DISCONTINUATION

Type of Discontinuation: Discontinuation of a category of service

1130.130 Discontinuation

GENERAL INFORMATION REQUIREMENTS

- 1. Identify the categories of service and the number of beds that are to be discontinued.**

Lake Forest Hospital proposes to discontinue 84 Long-Term Care beds.

- 2. Identify all of the other clinical services that are to be discontinued.**

No other clinical services will be discontinued.

- 3. Provide the anticipated date of discontinuation for each identified service.**

The original anticipated discontinuation date was by December 31, 2017, however, because of significant thunderstorms that hit northeast Illinois in mid-July and caused flooding and power losses at LFH, all patients had to be transferred to area facilities. LFH initiated a temporary suspension of the long-term care category of service at that time and as a result, the discontinuation will become permanent through HFSRB approval of this application.

- 4. Provide the anticipated use of the physical plant and equipment after the discontinuation.**

At this time, the use of the physical facility is not known. The future use of the Westmoreland Nursing Center, as well as the existing Lake Forest Hospital which will be vacated by early spring, 2018, is currently being evaluated. All options are being carefully considered in order to ensure the best use of the facilities and/or sites on campus. Equipment that is not at the end of useful life will be repurposed within the hospital.

- 5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.**

Medical records will be maintained by Lake Forest Hospital for a minimum of seven years.

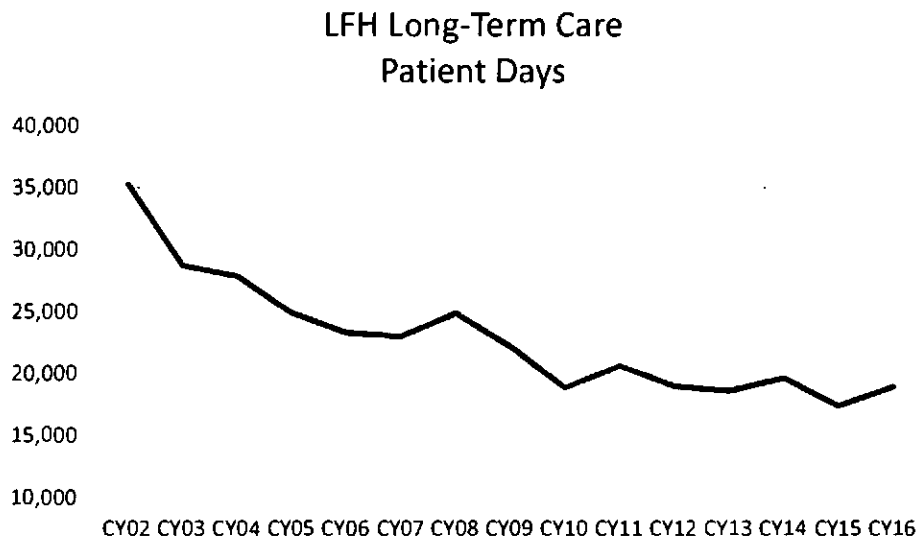
6. For applications involving the discontinuation of an entire facility, provide certification that all questionnaires and data required by HFSRB or DPH will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.

N/A – the proposed discontinuation is for the Long-Term Care category of service only. All questionnaires and data required by HFSRB or DPH will continue to be provided as required.

REASONS FOR DISCONTINUATION

In preparation for the completion of the new Northwestern Medicine Lake Forest Hospital, there was an extensive planning process to determine how to best advance the facilities and campus to serve the healthcare needs of the community. Through this process, it was determined that the required financial, additional regulatory, and operating resources to maintain an independent custodial care facility on the Lake Forest Hospital Campus, once the hospital relocates to its new location, were significant.

Additionally, since 2002, the long-term care patient days at LFH have decreased by almost 50%. Since 2012, the annual occupancies of the 84 beds have averaged 61%, far below the State's occupancy standard of 90%.



Because of these factors, maintaining the long-term care beds at LFH was determined to not be a feasible option. With the discontinuation of the long-term care beds, LFH can focus on further expanding access to acute care services for the community.

IMPACT ON ACCESS

- 1. Document that the discontinuation of each service and whether or not it will have an adverse effect upon access to care for residents of the facility's market area.**

Given the low volume of the service and calculated long-term care bed excess for Lake County of 326 beds, we do not believe that there will be any negative impact on access to care for the residents of Lake County. Additionally, there are 22 long-term care providers in Lake County who have average annual occupancies of less than the State's occupancy standard of 90% so this discontinuation will lead to higher utilization rates for some area providers.

- 2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.**

A request for impact statement was requested of all long-term care providers in Lake County (see next page).

Additionally, LFH has developed formal relationships with five facilities to accept transfers from LFH. These five facilities collectively have hundreds of beds to accommodate LFH patients. Since the announcement of our proposed discontinuation, other area facilities have reached out to offer their available beds as well.

Lake Forest Place

1100 Pembridge Drive
Lake Forest, Illinois 60045
847-604-6700
www.presbyterianhomes.org



June 20, 2017

Mr. Thomas J. McAfee
President
Northwestern Medicine Lake Forest Hospital
660 North Westmoreland Road
Lake Forest, IL 60045

RE: Discontinuation of Northwestern Medicine Lake Forest Hospital Skilled Nursing Beds

Dear Mr. McAfee:

We received your correspondence from May 23 regarding the discontinuation of long term care beds at Northwestern Medicine Lake Forest Hospital. Our community, Lake Forest Place, has the capacity to accommodate both some of your current custodial residents as well as future short term post-acute care patients. We have a 50 bed licensed unit with private rooms and we can offer comprehensive skilled nursing care on site.

Our team is ready to offer on-site evaluation services to your patients and support to your team in any way needed to ensure a seamless transition of care. If you have any further questions or need any additional information about our community, please do not hesitate to contact me at 847.604.6601 or gbrichacek@presbyterianhomes.org.

Sincerely,

Glenn Brichacek, PhD
Executive Director

Westminster Place

3200 Grant Street
Evanston, Illinois 60201
847-492-2800



June 20, 2017

Mr. Thomas J. McAfee
President
Northwestern Medicine Lake Forest Hospital
660 North Westmoreland Road
Lake Forest, IL 60045

RE: Discontinuation of Northwestern Medicine Lake Forest Hospital Skilled Nursing Beds

Dear Mr. McAfee:

We received your correspondence from May 23 regarding the discontinuation of long term care beds at Northwestern Medicine Lake Forest Hospital. Our community, Westminster Place, has the capacity to accommodate both some of your current custodial residents as well as future short term post-acute care patients. We have 104 skilled nursing care certified Medicare and licensed beds in McGaw and 95 licensed intermediate care beds in Foster Pavilion.

Our team is ready to offer on-site evaluation services to your patients and support to your team in any way needed to ensure a seamless transition of care. If you have any further questions or need any additional information about our community, please do not hesitate to contact me at 847.492.2900 or tswortzel@presbyterianhomes.org.

Sincerely,

Todd F. Swortzel
President & CEO - Presbyterian Homes
Interim Executive Director - Westminster Place

TFS/egb

ATTACHMENT-10

The Moorings of Arlington Heights



811 Central Road
Arlington Heights, Illinois 60005
847-437-6700
www.presbyterianhomes.org

June 26, 2017

Mr. Thomas J. McAfee
President
Northwestern Medicine Lake Forest Hospital
660 North Westmoreland Road
Lake Forest, IL 60045

RE: Discontinuation of Northwestern Medicine Lake Forest Hospital Skilled Nursing Beds

Dear Mr. McAfee:

We received your correspondence from May 23 regarding the discontinuation of long term care beds at Northwestern Medicine Lake Forest Hospital. Our community, The Moorings of Arlington Heights, has the capacity to accommodate both some of your current custodial residents as well as future short term post-acute care patients. We have a 96 bed licensed unit with shared and private rooms and we can offer comprehensive skilled nursing care on site.

Our team is ready to offer on-site evaluation services to your patients and support to your team in any way needed to ensure a seamless transition of care. If you have any further questions or need any additional information about our community, please do not hesitate to contact me at 847-956-4442 or lvandermark@presbyterianhomes.org.

Sincerely,

Lisa Vandermark
Executive Director

ATTACHMENT-10

June 26, 2017

Mr. Thomas J. McAfee
President
Northwestern Medicine Lake Forest Hospital
660 North Westmoreland Road
Lake Forest, IL 60045


RE: Discontinuation of Northwestern Medicine Lake Forest Hospital Skilled Nursing Beds

Dear Mr. McAfee:

We received your correspondence from June 19, 2017 regarding the discontinuation of long-term care beds at Northwestern Medicine Lake Forest Hospital. Our facility, Whitehall of Deerfield, has capability to accommodate both your current custodial residents as well as future short-term post-acute care patient needs. We have a 55 bed unit with both semi private and private room options for custodial/long-term care residents and an additional 119 beds for comprehensive skilled nursing care for short-term rehabilitation patients.

Our team is ready to offer on site evaluation services to your patients and to support your team in any way needed to ensure a seamless transition of care. If you have any further questions or need any additional information about our facility, please do not hesitate to contact me directly at 847.580.8287.

Sincerely,



Jeremy Kanter
Administrator

Cc: Bridget S. Orth

300 Waukegan Road
Deerfield, Illinois 60015

847.945.4600 phone
847.580.8480 fax

whitehallofdeerfield.com

-- -- --
LEGACY
HEALTHCARE

June 20, 2017

Mr. Thomas J. McAfee
President
Northwestern Medicine Lake Forest Hospital
660 North Westmoreland Road
Lake Forest, IL 60045

RE: Discontinuation of Northwestern Medicine Lake Forest Hospital Skilled Nursing Beds

Dear Mr. McAfee:

We received your correspondence on June 1st, 2017 regarding the discontinuation of long term care beds at Northwestern Medicine Lake Forest Hospital. Our facilities, Warren Barr Lincolnshire and Warren Barr North Shore, have the capability to accommodate both your current custodial residents as well as future short term post-acute care patient needs. We have 290 beds with both semi private and private room options and offer comprehensive skilled nursing care on site.

If you are interested in potentially building a relationship with Facility, our team can provide on site evaluation services to your patients and can support your team in any way needed to ensure a seamless transition of care, if potential relationship is to be established. If you have any further questions, need any additional information about our facility, or would like to establish a relationship with the facility, please do not hesitate to contact me at (224) 601-4833.

Additionally, this letter is not meant to be an agreement. Therefore, it is understood that (i) no liabilities or obligations are intended to be created by this letter by the parties hereto; (ii) this letter is not intended to constitute a legally binding agreement; and (iii) no binding obligation will be created unless and until a written agreement evidencing such obligation is duly executed and delivered by the parties.

Sincerely,
Erik Iverson
Vice President of Business Development
Legacy Healthcare, Warren Barr
(224) 601-4833



LEGACY HEALTHCARE FINANCIAL SERVICES, LLC



Rehabilitation and Healthcare Center

June 23, 2017

Northwestern Medicine
Ms. Bridget S. Orth
251 East Huron Street
Chicago, Illinois 60611-2908

**RE: Impact Determination for Discontinuation of Long Term Care Service
Northwestern Medicine Lake Forest Hospital**

Dear Ms. Orth:

We would like to acknowledge receipt of your June 19, 2017 letter. We are responding to your request for an impact determination regarding the discontinuation of services at Westmoreland's Nursing Center, 84-bed long-term care facility in Lake Forest, Illinois.

We at Libertyville Manor are saddened to see a quality care provider discontinue a service that provided excellent care to their community for many years. We also acknowledge that in today's environment regulator changes make providing skilled care a much more challenging endeavor. We can understand and appreciate the influences this has in one's future planning.

We do not believe there will be a negative impact on Libertyville Manor and its operation as a result of this change at Northwestern Medicine in Lake Forest, Illinois. We would like to wish Northwestern Medicine Lake Forest continued success in their future and in all their fields of healthcare.

Respectfully,

Mr. Milan Stokovich
Assistant Administrator

cc: Copy for File

June 19, 2017

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Prairieview Nursing Unit
6000 Garlands Lane
Barrington, IL 60010

**RE: *Request for Impact Determination
Discontinuation of Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital***

Dear Director:

Northwestern Medicine Lake Forest Hospital is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending HFSRB approval.

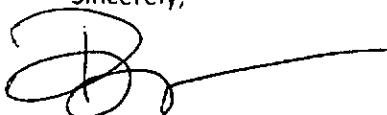
In preparation for the completion of the new Northwestern Medicine Lake Forest Hospital, we engaged in an extensive planning process to determine how to best advance our facilities and campus to serve the healthcare needs of the community. Through this process, we have determined that the required financial resources and regulatory process to maintain an independent custodial care facility on the Lake Forest Hospital Campus, once the hospital relocates to its new location, is no longer a feasible option.

Since FY12, the long-term care beds at LFH have had average annual occupancies between 56.7% - 68.8%, far below the State's occupancy standard of 90%. Additionally, the State's calculation of long-term care bed need for Lake County shows an excess of 326 beds.

As part of the discontinuation process, and consistent with the requirements of Section 1110.130, you are hereby asked to, within 15 days, identify any impact the proposed discontinuation of the long-term care category of service will have on your facility.

Thank you for your prompt attention to this request.

Sincerely,



Bridget S. Orth
Regulatory Planning

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BARRINGTON, IL 60010

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Postage \$0.49
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06/20/2017

Sent To Prairieview
 Street and Apt. No., or P.O. Box No. 6000 Garlands Lane
 City, State, ZIP+4® Barrington, IL 60010
 PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.
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1. Article Addressed to:

Prairieview
6000 Garlands Lane
Barrington, IL 60010



9590 9402 2841 7069 3416 18

2. Article Number (Transfer from service label)

7017 0660 0000 4510 1095

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A. Signature X Bedala ☐ Agent
☐ Addressee
 B. Received by (Printed Name) ALEXANDRA BOON
 C. Date of Delivery
 D. Is delivery address different from item 1? ☐ Yes
 If YES, enter delivery address below: ☐ No

3. Service Type
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PS Form 3811, July 2015 PSN 7530-02-000-9053

Domestic Return Receipt

June 19, 2017

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Lexington of Lake Zurich
900 South Rand Road
Lake Zurich, IL 60047

**RE: *Request for Impact Determination
Discontinuation of Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital***

Dear Director:

Northwestern Medicine Lake Forest Hospital is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending HFSRB approval.

In preparation for the completion of the new Northwestern Medicine Lake Forest Hospital, we engaged in an extensive planning process to determine how to best advance our facilities and campus to serve the healthcare needs of the community. Through this process, we have determined that the required financial resources and regulatory process to maintain an independent custodial care facility on the Lake Forest Hospital Campus, once the hospital relocates to its new location, is no longer a feasible option.

Since FY12, the long-term care beds at LFH have had average annual occupancies between 56.7% - 68.8%, far below the State's occupancy standard of 90%. Additionally, the State's calculation of long-term care bed need for Lake County shows an excess of 326 beds.

As part of the discontinuation process, and consistent with the requirements of Section 1110.130, you are hereby asked to, within 15 days, identify any impact the proposed discontinuation of the long-term care category of service will have on your facility.

Thank you for your prompt attention to this request.

Sincerely,



Bridget S. Orth
Regulatory Planning

7017 0660 0000 4510 1101

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| Street and Apt. No., or PO Box No. <u>9005 Rand Road</u> | |
| City, State, ZIP+4® <u>Lake Zurich, IL 60047</u> | |
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| <p>1. Article Addressed to:</p> <p><u>Lexington of Lake Zurich</u> <u>9005 Rand Road</u> <u>Lake Zurich, IL</u> <u>60047</u></p> <p>9590 9402 2841 7069 3416 01</p> | <p>3. Service Type</p> <p><input type="checkbox"/> Adult Signature <input type="checkbox"/> Priority Mail Express®</p> <p><input type="checkbox"/> Adult Signature Restricted Delivery <input type="checkbox"/> Registered Mail™</p> <p><input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Registered Mail Restricted Delivery</p> <p><input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Return Receipt for Merchandise</p> <p><input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Signature Confirmation™</p> <p><input type="checkbox"/> Collect on Delivery Restricted Delivery <input type="checkbox"/> Signature Confirmation Restricted Delivery</p> |
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| PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt | |

June 19, 2017

251 East Huron Street
Chicago, Illinois 60611-2908
312.926.2000
northwesternmedicine.org

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Alden-Long Grove Rehab/HC Center
2308 Old Hicks Road
Long Grove, IL 60047

**RE: *Request for Impact Determination
Discontinuation of Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital***

Dear Director:

Northwestern Medicine Lake Forest Hospital is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending HFSRB approval.

In preparation for the completion of the new Northwestern Medicine Lake Forest Hospital, we engaged in an extensive planning process to determine how to best advance our facilities and campus to serve the healthcare needs of the community. Through this process, we have determined that the required financial resources and regulatory process to maintain an independent custodial care facility on the Lake Forest Hospital Campus, once the hospital relocates to its new location, is no longer a feasible option.

Since FY12, the long-term care beds at LFH have had average annual occupancies between 56.7% - 68.8%, far below the State's occupancy standard of 90%. Additionally, the State's calculation of long-term care bed need for Lake County shows an excess of 326 beds.

As part of the discontinuation process, and consistent with the requirements of Section 1110.130, you are hereby asked to, within 15 days, identify any impact the proposed discontinuation of the long-term care category of service will have on your facility.

Thank you for your prompt attention to this request.


Sincerely,



Bridget S. Orth
Regulatory Planning

7017 0660 0000 4510 1118

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| <input type="checkbox"/> Adult Signature Restricted Delivery \$0.00 | |
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| Total Postage and Fees \$3.84 | |
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| Street and Apt. No., or PO Box No. 2308 Old Hicks Rd | |
| City, State, ZIP+4® Long Grove, IL 60047 | |
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| <p>1. Article Addressed to:</p> <p>Alden 2308 Old Hicks Road Long Grove, IL 60047</p> <p>9590 9402 2841 7069 3415 95</p> | <p>3. Service Type</p> <p><input type="checkbox"/> Adult Signature <input type="checkbox"/> Priority Mail Express®</p> <p><input type="checkbox"/> Adult Signature Restricted Delivery <input type="checkbox"/> Registered Mail™</p> <p><input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Registered Mail Restricted Delivery</p> <p><input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Return Receipt for Merchandise</p> <p><input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Signature Confirmation™</p> <p><input type="checkbox"/> Collect on Delivery Restricted Delivery <input type="checkbox"/> Signature Confirmation Restricted Delivery</p> |
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June 19, 2017

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Avantara Long Grove
1666 Checker Road
Long Grove, IL 60047

**RE: *Request for Impact Determination
Discontinuation of Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital***

Dear Director:

Northwestern Medicine Lake Forest Hospital is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending HFSRB approval.

In preparation for the completion of the new Northwestern Medicine Lake Forest Hospital, we engaged in an extensive planning process to determine how to best advance our facilities and campus to serve the healthcare needs of the community. Through this process, we have determined that the required financial resources and regulatory process to maintain an independent custodial care facility on the Lake Forest Hospital Campus, once the hospital relocates to its new location, is no longer a feasible option.

Since FY12, the long-term care beds at LFH have had average annual occupancies between 56.7% - 68.8%, far below the State's occupancy standard of 90%. Additionally, the State's calculation of long-term care bed need for Lake County shows an excess of 326 beds.

As part of the discontinuation process, and consistent with the requirements of Section 1110.130, you are hereby asked to, within 15 days, identify any impact the proposed discontinuation of the long-term care category of service will have on your facility.

Thank you for your prompt attention to this request.


Sincerely,



Bridget S. Orth
Regulatory Planning

7017 0660 0000 4510 1125

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| <p>1. Article Addressed to:</p> <p><u>Avantara Long Grove</u> <u>1666 Checker Road</u> <u>Long Grove, IL 60047</u></p> <p></p> <p>9590 9402 2841 7069 3423 63</p> | <p>3. Service Type</p> <p><input type="checkbox"/> Adult Signature</p> <p><input type="checkbox"/> Adult Signature Restricted Delivery</p> <p><input checked="" type="checkbox"/> Certified Mail®</p> <p><input type="checkbox"/> Certified Mail Restricted Delivery</p> <p><input type="checkbox"/> Collect on Delivery</p> <p><input type="checkbox"/> Collect on Delivery Restricted Delivery</p> <p><input type="checkbox"/> Insured Mail</p> <p><input type="checkbox"/> Priority Mail Express®</p> <p><input type="checkbox"/> Registered Mail™</p> <p><input type="checkbox"/> Registered Mail Restricted Delivery</p> <p><input type="checkbox"/> Return Receipt for Merchandise</p> <p><input type="checkbox"/> Signature Confirmation™</p> <p><input type="checkbox"/> Signature Confirmation Restricted Delivery</p> |
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PS Form 3811, July 2015 PSN 7530-02-000-9053

June 19, 2017

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Brentwood North Healthcare & Rehab
3705 Deerfield Road
Riverwoods, IL 60015

**RE: *Request for Impact Determination
Discontinuation of Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital***

Dear Director:

Northwestern Medicine Lake Forest Hospital is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending HFSRB approval.

In preparation for the completion of the new Northwestern Medicine Lake Forest Hospital, we engaged in an extensive planning process to determine how to best advance our facilities and campus to serve the healthcare needs of the community. Through this process, we have determined that the required financial resources and regulatory process to maintain an independent custodial care facility on the Lake Forest Hospital Campus, once the hospital relocates to its new location, is no longer a feasible option.

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As part of the discontinuation process, and consistent with the requirements of Section 1110.130, you are hereby asked to, within 15 days, identify any impact the proposed discontinuation of the long-term care category of service will have on your facility.

Thank you for your prompt attention to this request.

Sincerely,



Bridget S. Orth
Regulatory Planning

7017 0660 0000 4510 1132

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DEERFIELD, IL 60015

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 City, State, ZIP+4® Riverwoods, IL 60015

PS Form 3800, April 2015 PSN 7530-02-000-9047

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1. Article Addressed to:

Brentwood North Healthcare
3705 Deerfield Rd.
Riverwoods, IL
60015



9590 9402 2841 7069 3416 25

2. Article Number (Transfer from service label)

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A. Signature

X

☐ Agent
☐ Addressee

B. Received by (Printed Name)

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PS Form 3811, July 2015 PSN 7530-02-000-9053

Domestic Return Receipt

June 19, 2017

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Whitehall North
300 Waukegan Road
Deerfield, IL 60015

**RE: *Request for Impact Determination
Discontinuation of Long Term Core Category of Service
Northwestern Medicine Lake Forest Hospital***

Dear Director:

Northwestern Medicine Lake Forest Hospital is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending HFSRB approval.

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As part of the discontinuation process, and consistent with the requirements of Section 1110.130, you are hereby asked to, within 15 days, identify any impact the proposed discontinuation of the long-term care category of service will have on your facility.

Thank you for your prompt attention to this request.


Sincerely,



Bridget S. Orth
Regulatory Planning

7017 0660 0000 4510 1156

| | |
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| Sent To <i>Whitehall</i> Street and Apt. No. of PO Box No. <i>300 Waukegan Rd.</i> City, State, ZIP+4® <i>Deerfield, IL 60015</i> | |
| PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions | |

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| SENDER: COMPLETE THIS SECTION ■ Complete items 1, 2, and 3. ■ Print your name and address on the reverse so that we can return the card to you. ■ Attach this card to the back of the mailpiece, or on the front if space permits. 1. Article Addressed to: <i>Whitehall - North</i> <i>300 Waukegan Road</i> <i>Deerfield, IL 60015</i>  9590 9402 2841 7069 3407 89 2. Article Number (Transfer from service label) 7017 0660 0000 4510 1156 | COMPLETE THIS SECTION ON DELIVERY A. Signature <i>Linda Mette</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee B. Received by (Printed Name) <i>Linda Mette</i> C. Date of Delivery <i>6/23/17</i> D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No 3. Service Type <input type="checkbox"/> Adult Signature <input type="checkbox"/> Adult Signature Restricted Delivery <input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Collect on Delivery Restricted Delivery <input type="checkbox"/> Registered Mail™ <input type="checkbox"/> Registered Mail Restricted Delivery <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Signature Confirmation™ <input type="checkbox"/> Signature Confirmation Restricted Delivery <input type="checkbox"/> Priority Mail Express® |
|---|--|

PS Form 3811, July 2015 PSN 7530-02-000-9053

Domestic Return Receipt

June 19, 2017

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Sheltering Oak
27888 North Beech Street
Island Lake, IL 60042

**RE: *Request for Impact Determination
Discontinuation of Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital***

Dear Director:

Northwestern Medicine Lake Forest Hospital is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending HFSRB approval.

In preparation for the completion of the new Northwestern Medicine Lake Forest Hospital, we engaged in an extensive planning process to determine how to best advance our facilities and campus to serve the healthcare needs of the community. Through this process, we have determined that the required financial resources and regulatory process to maintain an independent custodial care facility on the Lake Forest Hospital Campus, once the hospital relocates to its new location, is no longer a feasible option.

Since FY12, the long-term care beds at LFH have had average annual occupancies between 56.7% - 68.8%, far below the State's occupancy standard of 90%. Additionally, the State's calculation of long-term care bed need for Lake County shows an excess of 326 beds.

As part of the discontinuation process, and consistent with the requirements of Section 1110.130, you are hereby asked to, within 15 days, identify any impact the proposed discontinuation of the long-term care category of service will have on your facility.

Thank you for your prompt attention to this request.

Sincerely,



Bridget S. Orth
Regulatory Planning

7017 0660 0000 4510 1163

| | |
|---|--|
| U.S. Postal Service™ CERTIFIED MAIL® RECEIPT Domestic Mail Only | |
| For delivery information, visit our website at www.usps.com ®. | |
| ISLAND LAKE, IL 60042 | |
| OFFICIAL USE | |
| Certified Mail Fee \$3.35 \$ Extra Services & Fees (check box, add fee as appropriate) <input type="checkbox"/> Return Receipt (hardcopy) \$2.75 <input type="checkbox"/> Return Receipt (electronic) \$0.00 <input type="checkbox"/> Certified Mail Restricted Delivery \$0.00 <input type="checkbox"/> Adult Signature Required \$0.00 <input type="checkbox"/> Adult Signature Restricted Delivery \$0.00 | 0093 02 Postmark Here 06/20/2017 |
| Postage \$0.49 \$ Total Postage and Fees \$6.59 \$ | |
| Sent To <i>Shelferny Oak</i> Street and Apt. No. or PO Box No. <i>27808 N. Beech St</i> City, State, ZIP+4® <i>Island Lake, IL 60042</i> | |
| PS Form 3800, April 2015 PSN 7537-02-030-9047 See Reverse for Instructions | |

June 19, 2017

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Wauconda Healthcare & Rehab
176 Thomas Court
Wauconda, IL 60084

**RE: *Request for Impact Determination
Discontinuation of Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital***

Dear Director:

Northwestern Medicine Lake Forest Hospital is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending HFSRB approval.

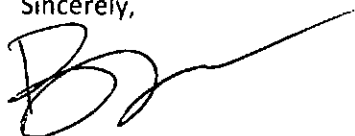
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As part of the discontinuation process, and consistent with the requirements of Section 1110.130, you are hereby asked to, within 15 days, identify any impact the proposed discontinuation of the long-term care category of service will have on your facility.

Thank you for your prompt attention to this request.

Sincerely,



Bridget S. Orth
Regulatory Planning

7017 0660 0000 4510 1170

| U.S. Postal Service™ CERTIFIED MAIL® RECEIPT Domestic Mail Only | |
|---|-----------------------------|
| For delivery information, visit our website at www.usps.com | |
| WAUCONDA, IL 60084 | |
| OFFICIAL USE | |
| Certified Mail Fee \$3.35 | 0093 02 |
| Extra Services & Fees (check box, add fee as appropriate) | |
| <input type="checkbox"/> Return Receipt (hardcopy) \$0.00 | |
| <input type="checkbox"/> Return Receipt (electronic) \$0.00 | |
| <input type="checkbox"/> Certified Mail Restricted Delivery \$0.00 | |
| <input type="checkbox"/> Adult Signature Required \$0.00 | |
| <input type="checkbox"/> Adult Signature Restricted Delivery \$0.00 | |
| Postage \$0.49 | Postmark Here 06/20/2017 |
| Total Postage and Fees \$6.59 | |
| Sent To Wauconda Healthcare 176 Thomas Court Wauconda, IL 60084 | |
| PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions | |

| SENDER: COMPLETE THIS SECTION | COMPLETE THIS SECTION ON DELIVERY |
|--|--|
| <ul style="list-style-type: none"> Complete items 1, 2, and 3. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. | <p>A. Signature X <i>Paul</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) C. Date of Delivery</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> |
| <p>1. Article Addressed to:</p> <p>Wauconda Healthcare 176 Thomas Court Wauconda, IL 60084</p> | <p>3. Service Type</p> <p><input type="checkbox"/> Priority Mail Express® <input type="checkbox"/> Registered Mail™ <input type="checkbox"/> Registered Mail Restricted Delivery <input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Signature Confirmation™ <input type="checkbox"/> Signature Confirmation Restricted Delivery</p> |
| <p>2. Article Number (Transfer from service label)</p> <p>7017 0660 0000 4510 1170</p> | <p><input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Collect on Delivery Restricted Delivery</p> |
| <p>PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt</p> | |

June 19, 2017

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Hillcrest Retirement Village
1740 Circuit Drive
Round Lake Beach, IL 60073

**RE: *Request for Impact Determination
Discontinuation of Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital***

Dear Director:

Northwestern Medicine Lake Forest Hospital is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending HFSRB approval.

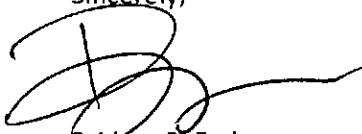
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As part of the discontinuation process, and consistent with the requirements of Section 1110.130, you are hereby asked to, within 15 days, identify any impact the proposed discontinuation of the long-term care category of service will have on your facility.

Thank you for your prompt attention to this request.

Sincerely,



Bridget S. Orth
Regulatory Planning

7017 0660 0000 4510 1187

U.S. Postal Service™
CERTIFIED MAIL® RECEIPT
Domestic Mail Only

For delivery information, visit our website at www.usps.com®.

ROUND LAKE BEACH, IL 60073

OFFICIAL USE

Certified Mail Fee \$3.35

Extra Services & Fees (check box, add fee as appropriate)
☐ Return Receipt (hardcopy) \$0.00
☐ Return Receipt (electronic) \$0.00
☐ Certified Mail Restricted Delivery \$0.00
☐ Adult Signature Required \$0.00
☐ Adult Signature Restricted Delivery \$0.00

Postage \$0.49

Total Postage and Fees \$6.59

0093
02

Postmark
Here

06/20/2017

Sent To
Street and Apt. No., or PO Box No.
City, State, ZIP+4®

Hillcrest
1740 Circuit Dr.
Round Lake Beach, IL 60073

PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions

SENDER: COMPLETE THIS SECTION


■ Complete items 1, 2, and 3.

■ Print your name and address on the reverse so that we can return the card to you.

■ Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

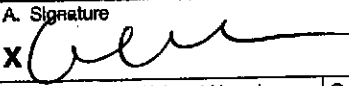
Hillcrest Retirement Village
1740 Circuit Drive
Round Lake Beach, IL 60073


9590 9402 2841 7069 3407 96

2. Article Number (Transfer from service label)

7017 0660 0000 4510 1187

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X  ☐ Agent
☐ Addressee

B. Received by (Printed Name)
Rosen

C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☒ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Mail
☐ Mail Restricted Delivery

☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

PS Form 3811, July 2015 PSN 7580-02-000-9053 Domestic Return Receipt

55

ATTACHMENT-10

June 19, 2017

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Transitional Care of Lake County
850 East U.S. Highway 45
Mundelein, IL 60060

**RE: *Request for Impact Determination
Discontinuation of Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital***

Dear Director:

Northwestern Medicine Lake Forest Hospital is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending HFSRB approval.

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As part of the discontinuation process, and consistent with the requirements of Section 1110.130, you are hereby asked to, within 15 days, identify any impact the proposed discontinuation of the long-term care category of service will have on your facility.

Thank you for your prompt attention to this request.

Sincerely,



Bridget S. Orth
Regulatory Planning

7017 0660 0000 4510 1194

| U.S. Postal Service™ CERTIFIED MAIL® RECEIPT Domestic Mail Only | |
|---|------------|
| For delivery information, visit our website at www.usps.com | |
| MUNDELEIN, IL 60060 | |
| OFFICIAL USE | |
| Certified Mail Fee \$3.35 | 0093 |
| Extra Services & Fees (check box, add fee as appropriate) | 02 |
| <input type="checkbox"/> Return Receipt (hardcopy) \$0.00 | Postmark |
| <input type="checkbox"/> Return Receipt (electronic) \$0.00 | Here |
| <input type="checkbox"/> Certified Mail Restricted Delivery \$0.00 | |
| <input type="checkbox"/> Adult Signature Required \$0.00 | |
| <input type="checkbox"/> Adult Signature Restricted Delivery \$0.00 | |
| Postage \$0.49 | 06/20/2017 |
| Total Postage and Fees \$6.59 | |
| Sent To Transitional Cave | |
| Street and Apt. No., or PO Box No. 850 E. U.S. Highway 45 | |
| City, State, ZIP+4® Mundelein, IL 60060 | |
| PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions | |

June 19, 2017

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Manor Care of Libertyville
1500 South Milwaukee Avenue
Libertyville, IL 60048

**RE: *Request for Impact Determination
Discontinuation of Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital***

Dear Director:

Northwestern Medicine Lake Forest Hospital is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending HFSRB approval.

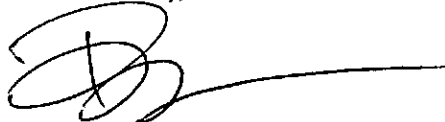
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Thank you for your prompt attention to this request.

Sincerely,



Bridget S. Drth
Regulatory Planning

7017 0660 0000 4510 1149

| U.S. Postal Service™ CERTIFIED MAIL® RECEIPT Domestic Mail Only | |
|---|------------------|
| For delivery information, visit our website at www.usps.com | |
| LIBERTYVILLE, IL 60048 | |
| OFFICIAL USE | |
| Certified Mail Fee \$3.35 | 0093 |
| Extra Services & Fees (check box, add fee as appropriate) | 02 |
| <input type="checkbox"/> Return Receipt (hardcopy) \$0.00 | Postmark Here |
| <input type="checkbox"/> Return Receipt (electronic) \$0.00 | |
| <input type="checkbox"/> Certified Mail Restricted Delivery \$0.00 | |
| <input type="checkbox"/> Adult Signature Required \$0.00 | |
| <input type="checkbox"/> Adult Signature Restricted Delivery \$0.00 | |
| Postage \$0.49 | 06/20/2017 |
| Total Postage and Fees \$6.59 | |
| Sent To Manor Care | |
| Street and Apt. No., or PO Box No. 1500 S. Milwaukee Ave | |
| City, State, ZIP+4® Libertyville, IL 60048 | |
| PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions | |

| SENDER: COMPLETE THIS SECTION | COMPLETE THIS SECTION ON DELIVERY |
|--|--|
| <ul style="list-style-type: none"> ■ Complete items 1, 2, and 3. ■ Print your name and address on the reverse so that we can return the card to you. ■ Attach this card to the back of the mailpiece, or on the front if space permits. | <p>A. Signature <input type="checkbox"/> Agent <input checked="" type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) <i>Sherry H. H...</i></p> <p>C. Date of Delivery</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> |
| <p>1. Article Addressed to:</p> <p>Manor Care 1500 S. Milwaukee Ave. Libertyville, IL 60048</p> | <p>3. Service Type</p> <p><input type="checkbox"/> Priority Mail Express® <input type="checkbox"/> Registered Mail™ <input type="checkbox"/> Registered Mail Restricted Delivery <input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Signature Confirmation™ <input type="checkbox"/> Signature Confirmation Restricted Delivery <input type="checkbox"/> Insured Mail <input type="checkbox"/> Mail Restricted Delivery</p> |
| <p>2. Article Number (Transfer from service label)</p> <p>7017 0660 0000 4510 1149</p> | <p>Domestic Return Receipt</p> |
| <p>PS Form 3811, July 2015 PSN 7530-02-000-9053</p> | |



9590 9402 2841 7069 3415 88

June 19, 2017

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Radford Green
901 Milwaukee Avenue
Lincolnshire, IL 60069

**RE: *Request for Impact Determination
Discontinuation of Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital***

Dear Director:

Northwestern Medicine Lake Forest Hospital is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending HFSRB approval.

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Thank you for your prompt attention to this request.

Sincerely,



Bridget S. Orth
Regulatory Planning

0021 0754 0000 0990 2707

U.S. Postal Service™
CERTIFIED MAIL® RECEIPT
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For delivery information, visit our website at www.usps.com

LINCOLNSHIRE, IL 60069

| | |
|--|--------|
| Certified Mail Fee | \$3.35 |
| Extra Services & Fees (check box, add fee as appropriate) | \$2.75 |
| <input type="checkbox"/> Return Receipt (hardcopy) | \$0.00 |
| <input type="checkbox"/> Return Receipt (electronic) | \$0.00 |
| <input type="checkbox"/> Certified Mail Restricted Delivery | \$0.00 |
| <input type="checkbox"/> Adult Signature Required | \$0.00 |
| <input type="checkbox"/> Adult Signature Restricted Delivery | \$0.00 |

| | |
|------------------------|--------|
| Postage | \$0.49 |
| Total Postage and Fees | \$6.59 |

0093
02
Postmark
Here
06/20/2017

Sent To Radford Green
 Street and Apt. No., or PO Box No. 901 Milwaukee Ave
 City, State, ZIP+4® Lincolnshire IL 60069

PS Form 3800, April 2015 PSN 7530-02-000 204/ See Reverse for Instructions

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
Radford Green
901 Milwaukee Ave.
Lincolnshire, IL 60069



9590 9402 2841 7069 3424 93

2. Article Number (Transfer from service label)
7017 0660 0000 4510 1200

PS Form 3811, July 2015 PSN 7530-02-000-9053

COMPLETE THIS SECTION ON DELIVERY

A. Signature
[Signature] ☐ Agent ☐ Addressee
 B. Received by (Printed Name) Jennifer Perlin
 C. Date of Delivery
 D. Is delivery address different from item 1? ☐ Yes ☐ No
 If YES, enter delivery address below:

3. Service Type
☐ Adult Signature ☐ Priority Mail Express®
☐ Adult Signature Restricted Delivery ☐ Registered Mail™
☒ Certified Mail® ☐ Registered Mail Restricted Delivery
☐ Certified Mail Restricted Delivery ☐ Return Receipt for Merchandise
☐ Collect on Delivery ☐ Signature Confirmation™
☐ Collect on Delivery Restricted Delivery ☐ Signature Confirmation Restricted Delivery
☐ Insured Mail ☐ Signature Confirmation Restricted Delivery
☐ Mail Restricted Delivery

Domestic Return Receipt

June 19, 2017

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Warren Barr Lincolnshire
150 Jamestown Lane
Lincolnshire, IL 60069

RE: *Request for Impact Determination*
Discontinuation of Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital

Dear Director:

Northwestern Medicine Lake Forest Hospital is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending HFSRB approval.

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Thank you for your prompt attention to this request.

Sincerely,



Bridget S. Orth
Regulatory Planning

ATTACHMENT-10

U.S. Postal Service™
CERTIFIED MAIL® RECEIPT
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For delivery information, visit our website at www.usps.com™.

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Certified Mail Fee \$3.35
 \$
 Extra Services & Fees (check box, add fee, add postage)
☐ Return Receipt (hardcopy) \$
☐ Return Receipt (electronic) \$0.00
☐ Certified Mail Restricted Delivery \$0.00
☐ Adult Signature Required \$0.00
☐ Adult Signature Restricted Delivery \$

0093
 02

Postmark
 Here

Postage \$0.49
 \$
 Total Postage and Fees \$3.84
 \$

06/20/2017

Sent To Warren Barr
 Street and Apt. No., or PO Box No. 150 Jamestown Lane
 City, State, ZIP+4® Lincolnshire IL 60069
 PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Warren Barr
 150 Jamestown Lane
 Lincolnshire, IL
 60069



9590 9402 2841 7069 3424 86

2. Article Number (Transfer from service label)

7017 0660 0000 4510 1217

PS Form 3811, July 2015 PSN 7530-02-000-9053

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X Marlene Nammis
 Agent Addressee

B. Received by (Printed Name)

Marlene Nammis

C. Date of Delivery

06/20/17

D. Is delivery address different from item 1? ☐ Yes ☒ No
 If YES, enter delivery address below:

3. Service Type

- ☐ Adult Signature
- ☐ Adult Signature Restricted Delivery
- ☒ Certified Mail®
- ☐ Certified Mail Restricted Delivery
- ☐ Collect on Delivery
- ☐ Collect on Delivery Restricted Delivery
- ☐ Full Restricted Delivery
- ☐ Priority Mail Express®
- ☐ Registered Mail™
- ☐ Registered Mail Restricted Delivery
- ☐ Return Receipt for Merchandise
- ☐ Signature Confirmation™
- ☐ Signature Confirmation Restricted Delivery

Domestic Return Receipt

June 19, 2017

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Libertyville Manor Extended Care
610 Peterson Road
Libertyville, IL 60048

**RE: Request for Impact Determination
Discontinuation of Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital**

Dear Director:

Northwestern Medicine Lake Forest Hospital is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending HFSRB approval.

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As part of the discontinuation process, and consistent with the requirements of Section 1110.130, you are hereby asked to, within 15 days, identify any impact the proposed discontinuation of the long-term care category of service will have on your facility.

Thank you for your prompt attention to this request.

Sincerely,



Bridget S. Orth
Regulatory Planning

7017 0660 0000 4510 1224

| U.S. Postal Service™ CERTIFIED MAIL® RECEIPT Domestic Mail Only | |
|--|------------------|
| For delivery information, visit our website at www.usps.com ™. | |
| LIBERTYVILLE, IL 60048 | |
| OFFICIAL USE | |
| Certified Mail Fee \$3.35 | 0093 02 |
| Extra Services & Fees (check box, add fee as appropriate) | Postmark Here |
| <input type="checkbox"/> Return Receipt (hardcopy) \$0.00 | 06/20/2017 |
| <input type="checkbox"/> Return Receipt (electronic) \$0.00 | |
| <input type="checkbox"/> Certified Mail Restricted Delivery \$0.00 | |
| <input type="checkbox"/> Adult Signature Required \$0.00 | |
| Postage \$0.49 | |
| Total Postage and Fees \$6.59 | |
| Sent To Libertyville Manor 610 Peterson Rd Libertyville, IL 60048 | |
| PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions | |

| SENDER: COMPLETE THIS SECTION | COMPLETE THIS SECTION ON DELIVERY |
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| <ul style="list-style-type: none"> Complete items 1, 2, and 3. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. | <p>A. Signature <i>Aura Ferrigan</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) <i>AURA FERRIGAN</i></p> <p>C. Date of Delivery</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> |
| <p>1. Article Addressed to:</p> <p>Libertyville Manor 610 Peterson Road Libertyville, IL 60048</p> <p>9590 9402 2841 7069 3424 79</p> | <p>3. Service Type</p> <p><input type="checkbox"/> Adult Signature <input type="checkbox"/> Priority Mail Express®</p> <p><input type="checkbox"/> Adult Signature Restricted Delivery <input type="checkbox"/> Registered Mail™</p> <p><input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Registered Mail Restricted Delivery</p> <p><input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Return Receipt for Merchandise</p> <p><input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Signature Confirmation™</p> <p><input type="checkbox"/> Collect on Delivery Restricted Delivery <input type="checkbox"/> Signature Confirmation Restricted Delivery</p> |
| <p>2. Article Number (Transfer from service label)</p> <p>7017 0660 0000 4510 1224</p> | |

PS Form 3811, July 2015 PSN 7530-02-000-9053

Domestic Return Receipt

June 19, 2017

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Winchester House Nursing Home
1125 North Milwaukee Avenue
Libertyville, IL 60048

**RE: *Request for Impact Determination
Discontinuation of Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital***

Dear Director:

Northwestern Medicine Lake Forest Hospital is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending HFSRB approval.

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Sincerely,



Bridget S. Orth
Regulatory Planning

U.S. Postal Service™
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LIBERTYVILLE, IL 60048

OFFICIAL USE

Certified Mail Fee \$3.35
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☐ Return Receipt (hardcopy) \$0.00
☐ Return Receipt (electronic) \$0.00
☐ Certified Mail Restricted Delivery \$0.00
☐ Adult Signature Required \$0.00
☐ Adult Signature Restricted Delivery \$0.00

Postage \$0.49
 Total Postage and Fees \$6.59

0093
 02

Postmark
 Here

06/20/2017

Sent To Winchester House
 Street and Apt. No., or P.O. Box No. 1125 N. Milwaukee Ave
 City, State, ZIP+4® Libertyville, IL 60048

PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions

7017 0660 0000 4510 1231

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Winchester House
 1125 N. Milwaukee Ave.
 Libertyville, IL
 60048



9590 9402 2841 7069 3424 62

2. Article Number (Transfer from envelope label)

7017 0660 0000 4510 1231

COMPLETER: THIS SECTION ON DELIVERY

A. Signature ☐ Agent
☒ Addressee

B. Received by (Printed Name) C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
 If YES, enter delivery address below: ☐ No

3. Service Type
- ☐ Adult Signature
 - ☐ Adult Signature Restricted Delivery
 - ☒ Certified Mail®
 - ☐ Certified Mail Restricted Delivery
 - ☐ Collect on Delivery
 - ☐ Insured Mail Delivery Restricted Delivery
 - ☐ Insured Mail Restricted Delivery (over \$500)
 - ☐ Priority Mail Express®
 - ☐ Registered Mail™
 - ☐ Registered Mail Restricted Delivery
 - ☐ Return Receipt for Merchandise
 - ☐ Signature Confirmation
 - ☐ Signature Confirmation Restricted Delivery

PS Form 3811, July 2015 PSN 7530-02-000-9053

Domestic Return Receipt

June 19, 2017

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

The Village at Victory Lakes
1055 East Grand Avenue
Lindenhurst, IL 60046

**RE: *Request for Impact Determination
Discontinuation of Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital***

Dear Director:

Northwestern Medicine Lake Forest Hospital is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending HFSRB approval.

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As part of the discontinuation process, and consistent with the requirements of Section 1110.130, you are hereby asked to, within 15 days, identify any impact the proposed discontinuation of the long-term care category of service will have on your facility.

Thank you for your prompt attention to this request.

Sincerely,



Bridget S. Orth
Regulatory Planning

7017 0660 0000 4510 1248

| U.S. Postal Service [™] | |
|---|---------------|
| CERTIFIED MAIL [®] RECEIPT | |
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| LAKE VILLAGE, IL 60046 | |
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| Certified Mail Fee \$3.35 | 0093 |
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| <input type="checkbox"/> Return Receipt (hardcopy) \$0.00 | Postmark Here |
| <input type="checkbox"/> Return Receipt (electronic) \$0.00 | |
| <input type="checkbox"/> Certified Mail Restricted Delivery \$0.00 | |
| <input type="checkbox"/> Adult Signature Required \$0.00 | |
| <input type="checkbox"/> Adult Signature Restricted Delivery \$0.00 | |
| Postage \$0.49 | 06/20/2017 |
| Total Postage and Fees \$6.59 | |
| Sent To The Village at Victory Lakes | |
| Street and Apt. No., or P.O. Box No. 1055 E. Grand Ave | |
| City, State, ZIP+4 [®] Waukegan, IL 60046 | |
| PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions | |

| SENDER: COMPLETE THIS SECTION | COMPLETE THIS SECTION ON DELIVERY |
|--|--|
| <ul style="list-style-type: none"> Complete items 1, 2, and 3. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. | <p>A. Signature x Margo Jesse <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by: _____ Date of Delivery _____</p> <p>D. Is delivery from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> |
| <p>1. Article Addressed to:</p> <p>The Village @ Victory Lakes 1055 E. Grand Ave. Waukegan, IL 60046</p> <p>9590 9402 2841 7069 3424 55</p> | <p>3. Service Type</p> <p><input type="checkbox"/> Adult Signature <input type="checkbox"/> Priority Mail Express[®]</p> <p><input type="checkbox"/> Adult Signature Restricted Delivery <input type="checkbox"/> Registered Mail[™]</p> <p><input checked="" type="checkbox"/> Certified Mail[®] <input type="checkbox"/> Registered Mail Restricted Delivery</p> <p><input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Return Receipt for Merchandise</p> <p><input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Signature Confirmation[™]</p> <p><input type="checkbox"/> Collect on Delivery Restricted Delivery <input type="checkbox"/> Signature Confirmation Restricted Delivery</p> <p><input type="checkbox"/> Insured Mail <input type="checkbox"/> Restricted Delivery</p> |
| <p>2. Article Number (Transfer from service label)</p> <p>7017 0660 0000 4510 1248</p> | |
| PS Form 3811, July 2015 PSN 7530-02-000-9053 | Domestic Return Receipt |

June 19, 2017

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Lake Forest Place
1100 Pembridge Drive
Lake Forest, IL 60045

**RE: *Request for Impact Determination
Discontinuation of Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital***

Dear Director:

Northwestern Medicine Lake Forest Hospital is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending HFSRB approval.

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As part of the discontinuation process, and consistent with the requirements of Section 1110.130, you are hereby asked to, within 15 days, identify any impact the proposed discontinuation of the long-term care category of service will have on your facility.

Thank you for your prompt attention to this request.

Sincerely,



Bridget S. Orth
Regulatory Planning

7017 0660 0000 4510 1255

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| For delivery information, visit our website at www.usps.com | |
| LAKE FOREST, IL 60045 | |
| OFFICIAL USE | |
| Certified Mail Fee \$3.35 | 0093 02 |
| Extra Services & Fees (check box, add fee to postage) | Postmark Here |
| <input type="checkbox"/> Return Receipt (hardcopy) \$2.75 | 06/20/2017 |
| <input type="checkbox"/> Return Receipt (electronic) \$0.00 | |
| <input type="checkbox"/> Certified Mail Restricted Delivery \$0.00 | |
| <input type="checkbox"/> Adult Signature Required \$0.00 | |
| <input type="checkbox"/> Adult Signature Restricted Delivery \$0.00 | |
| Postage \$0.49 | |
| Total Postage and Fees \$6.59 | |
| Sent To Lake Forest Place | |
| Street and Apt. No., or PO Box No. 1100 Pembroke Drive | |
| City, State, ZIP+4® Lake Forest, IL 60045 | |
| PS Form 3800, April 2015 PSN 7530-02-000-9053 See Reverse for Instructions | |

| SENDER: COMPLETE THIS SECTION | COMPLETE THIS SECTION ON DELIVERY |
|--|--|
| <ul style="list-style-type: none"> ■ Complete items 1, 2, and 3. ■ Print your name and address on the reverse so that we can return the card to you. ■ Attach this card to the back of the mailpiece, or on the front if space permits. | <p>A. Signature <input type="checkbox"/> Agent X SULLIVAN <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) C. Date of Delivery 6/22/17</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> |
| <p>1. Article Addressed to:</p> <p>Lake Forest Place 1100 Pembroke Drive Lake Forest, IL 60045</p> | <p>3. Service Type</p> <p><input type="checkbox"/> Priority Mail Express® <input type="checkbox"/> Registered Mail™ <input type="checkbox"/> Registered Mail Restricted Delivery <input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Signature Confirmation™ <input type="checkbox"/> Signature Confirmation Restricted Delivery</p> |
| <p>2. Article Number (Transfer from service label)</p> <p>7017 0660 0000 4510 1255</p> | <p>9590 9402 2841 7069 3424 48</p> |
| <p>PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt</p> | |

June 19, 2017

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Warren Barr North Shore
2773 Skokie Valley Road
Highland Park, IL 60035

**RE: *Request for Impact Determination
Discontinuation of Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital***

Dear Director:

Northwestern Medicine Lake Forest Hospital is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending HFSRB approval.


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Thank you for your prompt attention to this request.

Sincerely,



Bridget S. Orth
Regulatory Planning

7017 0660 0000 4510 1262

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| For delivery information, visit our website at www.usps.com | |
| HIGHLAND PARK, IL 60035 | |
| Certified Mail Fee \$3.35 | 0093 02 |
| Extra Services & Fees (check box, add fee as appropriate) | Postmark Here |
| <input type="checkbox"/> Return Receipt (hardcopy) \$0.00 | 06/20/2017 |
| <input type="checkbox"/> Return Receipt (electronic) \$0.00 | |
| <input type="checkbox"/> Certified Mail Restricted Delivery \$0.00 | |
| <input type="checkbox"/> Adult Signature Required \$0.00 | |
| Postage \$0.49 | |
| Total Postage and Fees \$6.59 | |
| Sent To Warren Barr | |
| Street and Apt. No., or PO Box No. 2773 Skokie Valley Rd | |
| City, State, ZIP+4® Highland Park, IL 60035 | |
| PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions | |

| SENDER: COMPLETE THIS SECTION | COMPLETE THIS SECTION ON DELIVERY |
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| <ul style="list-style-type: none"> Complete items 1, 2, and 3. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. | <p>A. Signature <input checked="" type="checkbox"/> Agent <input checked="" type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name)</p> <p>C. Date of Delivery</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> |
| <p>1. Article Addressed to:</p> <p>Warren Barr 2773 Skokie Valley Rd Highland Park, IL 60035</p> | <p>3. Service Type</p> <p><input type="checkbox"/> Adult Signature <input type="checkbox"/> Adult Signature Restricted Delivery <input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Collect on Delivery Restricted Delivery</p> <p><input type="checkbox"/> Priority Mail Express® <input type="checkbox"/> Registered Mail™ <input type="checkbox"/> Registered Mail Restricted Delivery <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Signature Confirmation™ <input type="checkbox"/> Signature Confirmation Restricted Delivery</p> |
| <p>2. Article Number (Transfer from service label)</p> <p>7017 0660 0000 4510 1262</p> | |

PS Form 3811, July 2015 PSN 7530-02-000-9053

Domestic Return Receipt

June 19, 2017

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Aperion Care Highwood
50 Pleasant Avenue
Highwood Park, IL 60040

**RE: *Request for Impact Determination
Discontinuation of Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital***

Dear Director:

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Sincerely,



Bridget S. Drth
Regulatory Planning

U.S. Postal Service™
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OFFICIAL USE

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Extra Services & Fees (check box, add fee as appropriate)

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| <input type="checkbox"/> Return Receipt (hardcopy) | \$2.75 |
| <input type="checkbox"/> Return Receipt (electronic) | \$0.00 |
| <input type="checkbox"/> Certified Mail Restricted Delivery | \$0.00 |
| <input type="checkbox"/> Adult Signature Required | \$0.00 |
| <input type="checkbox"/> Adult Signature Restricted Delivery | \$0.00 |

Postage \$0.49

Total Postage and Fees \$6.59

Sent To *Aperion Care*
Street and Apt. No., or PO Box No. *50 Pleasant Ave*
City, State, ZIP+4® *Highwood, IL 60040*

PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions

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7017 0660 0000 4510 1279

| SENDER: COMPLETE THIS SECTION | COMPLETE THIS SECTION ON DELIVERY | | |
|--|---|--|--|
| <p>■ Complete items 1, 2, and 3.</p> <p>■ Print your name and address on the reverse so that we can return the card to you.</p> <p>■ Attach this card to the back of the mailpiece, or on the front if space permits.</p> <p>1. Article Addressed to:</p> <p><i>Aperion Care</i> <i>50 Pleasant Ave.</i> <i>Highwood, IL 60040</i></p> <p>2. Article Number (Transfer from service label)</p> <p>7017 0660 0000 4510 1279</p> | <p>A. Signature</p> <p><i>[Signature]</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) C. Date of Delivery</p> <p><i>Justin Long</i></p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, enter delivery address below:</p> <p>3. Service Type</p> <table border="0"> <tr> <td> <input type="checkbox"/> Adult Signature <input type="checkbox"/> Adult Signature Restricted Delivery <input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Collect on Delivery Restricted Delivery <input type="checkbox"/> Insured Mail <input type="checkbox"/> Mail Restricted Delivery (\$500) </td> <td> <input type="checkbox"/> Priority Mail Express® <input type="checkbox"/> Registered Mail™ <input type="checkbox"/> Registered Mail Restricted Delivery <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Signature Confirmation™ <input type="checkbox"/> Signature Confirmation Restricted Delivery </td> </tr> </table> | <input type="checkbox"/> Adult Signature <input type="checkbox"/> Adult Signature Restricted Delivery <input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Collect on Delivery Restricted Delivery <input type="checkbox"/> Insured Mail <input type="checkbox"/> Mail Restricted Delivery (\$500) | <input type="checkbox"/> Priority Mail Express® <input type="checkbox"/> Registered Mail™ <input type="checkbox"/> Registered Mail Restricted Delivery <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Signature Confirmation™ <input type="checkbox"/> Signature Confirmation Restricted Delivery |
| <input type="checkbox"/> Adult Signature <input type="checkbox"/> Adult Signature Restricted Delivery <input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Collect on Delivery Restricted Delivery <input type="checkbox"/> Insured Mail <input type="checkbox"/> Mail Restricted Delivery (\$500) | <input type="checkbox"/> Priority Mail Express® <input type="checkbox"/> Registered Mail™ <input type="checkbox"/> Registered Mail Restricted Delivery <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Signature Confirmation™ <input type="checkbox"/> Signature Confirmation Restricted Delivery | | |

9590 9402 2841 7069 3423 56

PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt

June 19, 2017

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Claridge Healthcare Center
700 Jenkisson Avenue
Lake Bluff, IL 60044

**RE: *Request for Impact Determination
Discontinuation of Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital***

Dear Director:

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Thank you for your prompt attention to this request.


Sincerely,



Bridget S. Orth
Regulatory Planning

7017 0660 0000 4510 1286

| | |
|---|--------------------------------|
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| For delivery information, visit our website at www.usps.com ®. | |
| LAKE BLUFF, IL 60044 | |
| Certified Mail Fee \$3.35 Extra Services & Fees (check box, add fee if appropriate) <input type="checkbox"/> Return Receipt (hardcopy) \$0.00 <input type="checkbox"/> Return Receipt (electronic) \$0.00 <input type="checkbox"/> Certified Mail Restricted Delivery \$0.00 <input type="checkbox"/> Adult Signature Required \$0.00 <input type="checkbox"/> Adult Signature Restricted Delivery \$0.00 | 0093 02 Postmark Here |
| Postage \$0.49 Total Postage and Fees \$6.59 | 06/20/2017 |
| Sent To Street and Apt. No., or PO Box No. City, State, ZIP+4® | |
| PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions | |

| | |
|---|--|
| SENDER: COMPLETE THIS SECTION <ul style="list-style-type: none"> Complete items 1, 2, and 3. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if it permits. | COMPLETE THIS SECTION ON DELIVERY A. Signature <input checked="" type="checkbox"/> E. Maxwell <input type="checkbox"/> Agent <input type="checkbox"/> Addressee B. Received by (Printed Name) C. Date of Delivery D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No |
| 1. Claridge Healthcare 700 Jenkisson Ave. Lake Bluff, IL 60044  9590 9402 2841 7069 3423 94 | 3. Service Type <input type="checkbox"/> Adult Signature <input type="checkbox"/> Adult Signature Restricted Delivery <input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Collect on Delivery Restricted Delivery <input type="checkbox"/> Insured Mail <input type="checkbox"/> Insured Mail Restricted Delivery (over \$500) <input type="checkbox"/> Priority Mail Express® <input type="checkbox"/> Registered Mail™ <input type="checkbox"/> Registered Mail Restricted Delivery <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Signature Confirmation™ <input type="checkbox"/> Signature Confirmation Restricted Delivery |
| 2. Article Number (Transfer from service label) 7017 0660 0000 4510 1286 | PS Form 3811, July 2015 PSN 7580-02-000-9053 Domestic Return Receipt |

June 19, 2017

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Glen Lake Terrace Nursing & Rehab
2222 West 14th Street
Waukegan, IL 60085

**RE: *Request for Impact Determination
Discontinuation of Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital***

Dear Director:

Northwestern Medicine Lake Forest Hospital is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending HFSRB approval.

In preparation for the completion of the new Northwestern Medicine Lake Forest Hospital, we engaged in an extensive planning process to determine how to best advance our facilities and campus to serve the healthcare needs of the community. Through this process, we have determined that the required financial resources and regulatory process to maintain an independent custodial care facility on the Lake Forest Hospital Campus, once the hospital relocates to its new location, is no longer a feasible option.

Since FY12, the long-term care beds at LFH have had average annual occupancies between 56.7% - 68.8%, far below the State's occupancy standard of 90%. Additionally, the State's calculation of long-term care bed need for Lake County shows an excess of 326 beds.

As part of the discontinuation process, and consistent with the requirements of Section 1110.130, you are hereby asked to, within 15 days, identify any impact the proposed discontinuation of the long-term care category of service will have on your facility.

Thank you for your prompt attention to this request.

Sincerely,



Bridget S. Orth
Regulatory Planning

7017 0660 0000 4510 1293

| | |
|---|--------------------------------|
| U.S. Postal Service™ CERTIFIED MAIL® RECEIPT Domestic Mail Only | |
| For delivery information, visit our website at www.usps.com ™ | |
| OFFICIAL USE | |
| Certified Mail Fee \$3.35 Extra Services & Fees (check box, add fee as appropriate) <input type="checkbox"/> Return Receipt (hardcopy) \$0.00 <input type="checkbox"/> Return Receipt (electronic) \$0.00 <input type="checkbox"/> Certified Mail Restricted Delivery \$0.00 <input type="checkbox"/> Adult Signature Required \$0.00 <input type="checkbox"/> Adult Signature Restricted Delivery \$0.00 | 0093 02 Postmark Here |
| Postage \$0.49 Total Postage and Fees \$6.59 | 06/20/2017 |
| Sent To Street and Apt. No., or PO Box No. City, State, ZIP+4® Glen Lake Terrace 2222 W. 14th St Waukegan, IL 60085 | |
| PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions | |

| | |
|--|---|
| SENDER: COMPLETE THIS SECTION | COMPLETE THIS SECTION ON DELIVERY |
| <ul style="list-style-type: none"> ■ Complete items 1, 2, and 3. ■ Print your name and address on the reverse so that we can return the card to you. ■ Attach this card to the back of the mailpiece, or on the front if space permits. | A. Signature X Patricia Palmore <input type="checkbox"/> Agent <input type="checkbox"/> Addressee B. Received by (Printed Name) Patricia Palmore C. Date of Delivery 6/22/17 |
| 1. Article Addressed to: Glen Lake Terrace 2222 W. 14th St. Waukegan, IL 60085 | D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No |
| 2. Article Number (Transfer from service label) 9590 9402 2841 7069 3424 00 7017 0660 0000 4510 1293 | 3. Service Type <input type="checkbox"/> Adult Signature <input type="checkbox"/> Adult Signature Restricted Delivery <input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Collect on Delivery Restricted Delivery <input type="checkbox"/> Insured Mail® <input type="checkbox"/> Priority Mail Express® <input type="checkbox"/> Registered Mail™ <input type="checkbox"/> Registered Mail Restricted Delivery <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Signature Confirmation™ <input type="checkbox"/> Signature Confirmation Restricted Delivery |
| PS Form 3811, July 2015 PSN 7530-02-000-9053 | Domestic Return Receipt |

June 19, 2017

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Pavilion of Waukegan
2217 Washington Street
Waukegan, IL 60085

**RE: *Request for Impact Determination
Discontinuation of Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital***

Dear Director:

Northwestern Medicine Lake Forest Hospital is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending HFSRB approval.

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Thank you for your prompt attention to this request.

Sincerely,



Bridget S. Orth
Regulatory Planning

U.S. Postal Service™
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WAUKEGAN, IL 60085

OFFICIAL USE

Certified Mail Fee \$3.35
 Extra Services & Fees (check box, add fee as appropriate)
☐ Return Receipt (hardcopy) \$0.00
☐ Return Receipt (electronic) \$0.00
☐ Certified Mail Restricted Delivery \$0.00
☐ Adult Signature Required \$0.00
☐ Adult Signature Restricted Delivery \$0.00

Postage \$0.49
 Total Postage and Fees \$6.59

0093
 02

Postmark
 Here

06/20/2017

Sent To Pavilion
 Street and Apt. No. or PO Box No. 2217 Washington St
 City, State, ZIP+4® Waukegan, IL 60085

PS Form 3800, April 2015 PSN 7530-02-000-9017

See Reverse for Instructions

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Pavilion of Waukegan
 2217 Washington St.
 Waukegan, IL 60085



9590 9402 2841 7069 3423 87

2. Article Number (Transfer from service label)

7017 0660 0000 4510 1304

PS Form 3811, July 2015 PSN 7530-02-000-9053

COMPLETE THIS SECTION ON DELIVERY

A. Signature ☒ Agent ☐ Addressee
 B. Received by (Printed Name) Shantilya Nweh
 C. Date of Delivery 6-22-17
 D. Is delivery address different from item 1? ☐ Yes
 If YES, enter delivery address below: ☐ No

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☒ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Registered Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

Domestic Return Receipt

June 19, 2017

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

The Terrace Nursing Home
1615 Sunset Avenue
Waukegan, IL 60087

**RE: *Request for Impact Determination
Discontinuation of Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital***

Dear Director:

Northwestern Medicine Lake Forest Hospital is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending HFSRB approval.

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Since FY12, the long-term care beds at LFH have had average annual occupancies between 56.7% - 68.8%, far below the State's occupancy standard of 90%. Additionally, the State's calculation of long-term care bed need for Lake County shows an excess of 326 beds.

As part of the discontinuation process, and consistent with the requirements of Section 1110.130, you are hereby asked to, within 15 days, identify any impact the proposed discontinuation of the long-term care category of service will have on your facility.

Thank you for your prompt attention to this request.

Sincerely,



Bridget S. Orth
Regulatory Planning

7017 0660 0000 4510 1316

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|--|------------------|
| For delivery information, visit our website at www.usps.com ™. | |
| WAUKEGAN IL 60087 | |
| OFFICIAL USE | |
| Certified Mail Fee \$3.35 | 0093 02 |
| Extra Services & Fees (check box, add fee as appropriate) | Postmark Here |
| <input type="checkbox"/> Return Receipt (hardcopy) \$2.75 | |
| <input type="checkbox"/> Return Receipt (electronic) \$0.00 | |
| <input type="checkbox"/> Certified Mail Restricted Delivery \$0.00 | |
| <input type="checkbox"/> Adult Signature Required \$0.00 | |
| <input type="checkbox"/> Adult Signature Restricted Delivery \$0.00 | |
| Postage \$0.49 | 06/20/2017 |
| Total Postage and Fees \$6.59 | |
| Sent To The Terrace | |
| Street and Apt. No., or PO Box No. 1615 Sunset Ave | |
| City, State, ZIP+4® Waukegan, IL 60087 | |
| PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions | |

| SENDER: COMPLETE THIS SECTION | COMPLETE THIS SECTION ON DELIVERY |
|--|---|
| <ul style="list-style-type: none"> ■ Complete items 1, 2, and 3. ■ Print your name and address on the reverse so that we can return the card to you. ■ Attach this card to the back of the mailpiece, or on the front if space permits. | <p>A. Signature x <i>[Signature]</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) Shannon Sides C. Date of Delivery 6/22/17</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> |
| <p>1. Article Addressed to:</p> <p>The Terrace Nursing Home 1615 Sunset Avenue Waukegan, IL 60087</p> | |
| <p>2. Article Number (Transfer from service label) 7017 0660 0000 4510 1316</p> | <p>3. Service Type</p> <p><input type="checkbox"/> Adult Signature <input type="checkbox"/> Priority Mail Express® <input type="checkbox"/> Adult Signature Restricted Delivery <input type="checkbox"/> Registered Mail™ <input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Registered Mail Restricted Delivery <input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Signature Confirmation™ <input type="checkbox"/> Collect on Delivery Restricted Delivery <input type="checkbox"/> Signature Confirmation Restricted Delivery</p> <p>1 Mail 1 Mail Restricted Delivery (500)</p> |
| <p>PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt</p> | |

June 19, 2017

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Grove at the Lake
2534 Elim Avenue
Zion, IL 60099

**RE: *Request for Impact Determination
Discontinuation of Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital***

Dear Director:

Northwestern Medicine Lake Forest Hospital is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending HFSRB approval.

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Thank you for your prompt attention to this request.

Sincerely,



Bridget S. Orth
Regulatory Planning

7017 0660 0000 4510 1323

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|---|------------------|
| For delivery information, visit our website at www.usps.com . | |
| ZION, IL 60099 | |
| OFFICIAL USE | |
| Certified Mail Fee \$3.35 | 0093 02 |
| Extra Services & Fees (check box, add fee if appropriate) | Postmark Here |
| <input type="checkbox"/> Return Receipt (hardcopy) \$0.00 | 06/20/2017 |
| <input type="checkbox"/> Return Receipt (electronic) \$0.00 | |
| <input type="checkbox"/> Certified Mail Restricted Delivery \$0.00 | |
| <input type="checkbox"/> Adult Signature Required \$0.00 | |
| Postage \$0.49 | |
| Total Postage and Fees \$6.59 | |
| Sent To Grove at the Lake | |
| Street and Apt. No., or PO Box No. 2534 Elm Avenue | |
| City, State, ZIP+4® Zion, IL 60099 | |
| PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions | |

| SENDER: COMPLETE THIS SECTION | COMPLETE THIS SECTION ON DELIVERY |
|--|--|
| <ul style="list-style-type: none"> Complete items 1, 2, and 3. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. | <p>A. Signature <input checked="" type="checkbox"/> <i>Brooke Zavala</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) <i>Brooke Zavala</i> C. Date of Delivery <i>6.22.17</i></p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input checked="" type="checkbox"/> No</p> |
| <p>1. Article Addressed to:</p> <p>Grove at the Lake 2534 Elm Avenue Zion, IL 60099</p> <p>9590 9402 2841 7069 3423 70</p> | <p>3. Service Type</p> <p><input type="checkbox"/> Adult Signature <input type="checkbox"/> Priority Mail Express®</p> <p><input type="checkbox"/> Adult Signature Restricted Delivery <input type="checkbox"/> Registered Mail™</p> <p><input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Registered Mail Restricted Delivery</p> <p><input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Return Receipt for Merchandise</p> <p><input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Signature Confirmation™</p> <p><input type="checkbox"/> Collect on Delivery Restricted Delivery <input type="checkbox"/> Signature Confirmation Restricted Delivery</p> |
| <p>2. Article Number (Transfer from service label)</p> <p>7017 0660 0000 4510 1323</p> | |
| PS Form 3811, July 2015 PSN 7530-02-000-9053 | Domestic Return Receipt |

June 19, 2017

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Rolling Hills Manor Nursing Home
3615 16th Street
Zion, IL 60099

**RE: *Request for Impact Determination
Discontinuation of Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital***

Dear Director:

Northwestern Medicine Lake Forest Hospital is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending HFSRB approval.

In preparation for the completion of the new Northwestern Medicine Lake Forest Hospital, we engaged in an extensive planning process to determine how to best advance our facilities and campus to serve the healthcare needs of the community. Through this process, we have determined that the required financial resources and regulatory process to maintain an independent custodial care facility on the Lake Forest Hospital Campus, once the hospital relocates to its new location, is no longer a feasible option.

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As part of the discontinuation process, and consistent with the requirements of Section 1110.130, you are hereby asked to, within 15 days, identify any impact the proposed discontinuation of the long-term care category of service will have on your facility.

Thank you for your prompt attention to this request.

Sincerely,



Bridget S. Orth
Regulatory Planning

7017 0660 0000 4510 1330

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| U.S. Postal Service™ CERTIFIED MAIL® RECEIPT Domestic Mail Only | |
| For delivery information, visit our website at www.usps.com | |
| OFFICIAL USE | |
| Certified Mail Fee \$3.35 Extra Services & Fees (check box, add fee as appropriate) <input type="checkbox"/> Return Receipt (hardcopy) \$ \$0.00 <input type="checkbox"/> Return Receipt (electronic) \$ \$0.00 <input type="checkbox"/> Certified Mail Restricted Delivery \$ \$0.00 <input type="checkbox"/> Adult Signature Required \$ \$0.00 <input type="checkbox"/> Adult Signature Restricted Delivery \$ \$0.00 | 0093 02 Postmark Here 06/20/2017 |
| Postage \$ \$0.49 Total Postage and Fees \$ \$6.59 | |
| Sent To Rolling Hills Street and Apt. No., or PO Box No. 3615 16th st City, State, ZIP+4® 21011 IL 60099 | |
| PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions | |

| | |
|--|---|
| SENDER: COMPLETE THIS SECTION | COMPLETE THIS SECTION ON DELIVERY |
| <ul style="list-style-type: none"> Complete items 1, 2, and 3. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. | A. Signature x Bilama Watkins <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee B. Received by (Printed Name) B. WATKINS C. Date of Delivery 6/22/17 D. Is delivery address different from item 1? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If YES, enter delivery address below: |
| 1. Article Addressed to: Rolling Hills Manor 3615 16th st 21011, IL 60099 | |
| 2. Article Number (Transfer from service label) 7017 0660 0000 4510 1330 | 3. Service Type <input type="checkbox"/> Adult Signature <input type="checkbox"/> Priority Mail Express® <input type="checkbox"/> Adult Signature Restricted Delivery <input type="checkbox"/> Registered Mail™ <input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Registered Mail Restricted Delivery <input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Signature Confirmation™ <input type="checkbox"/> Collect on Delivery Restricted Delivery <input type="checkbox"/> Signature Confirmation Restricted Delivery |

July 13, 2017

Senator Julie A. Morrison
District 29
700 Osterman Avenue
Deerfield, IL 60015

**RE: *Notice of Discontinuation
Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital***

Dear Senator Morrison:

Northwestern Medicine Lake Forest Hospital (LFH) is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending Health Facilities and Services Review Board approval.

In preparation for the completion of the new LFH, we engaged in an extensive planning process to determine how to best advance our facilities and campus to serve the healthcare needs of the community. Through this process, we have determined that the required financial resources and regulatory process to maintain an independent custodial care facility on the Lake Forest Hospital Campus, once the hospital relocates to its new location, is no longer a feasible option.

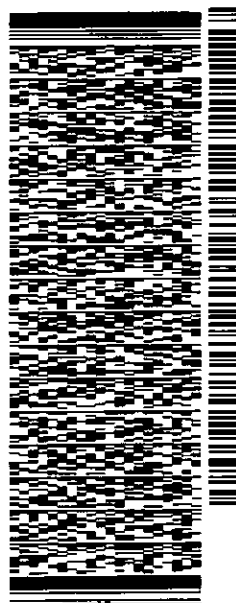
Patients and families have been notified of our plan for closure. We have developed formal relationships with five facilities to accept transfers from LFH. These five facilities collectively have hundreds of beds to accommodate LFH patients. Since the announcement of our proposed discontinuation, other area facilities have reached out to offer their available beds as well.

Please feel free to contact Rob Christie with any questions at 312-926-7527 or rchristi@nm.org.

Sincerely,



Bridget S. Orth
Regulatory Planning



DEERFIELD IL 60015
 (312) 926-8650
 REF
 PO

DEPT 1057

TO SENATOR JULIE MORRISON
 SENATE DISTRICT 29
 700 OSTERMAN AVENUE

ORIGIN ID: CHIA (312) 926-8650
 BRIDGET ORTH
 NORTHWESTERN MEMORIAL HEALTHCARE
 211 E ONTARIO ST
 SUITE 1750
 CHICAGO, IL 60611
 UNITED STATES US

SHIP DATE: 13 JUL 17
 ACTWGT: 0.50 LB
 CAD: 109257817MWSX3100
 BILL THIRD PARTY

546J1K0C253C1

After printing this label:

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2. Place label in shipping pouch and affix it to your shipment so that the barcode portion of the label can be read and scanned.

Shipment Summary

| | |
|---|--|
| Ship Date: 7/13/2017 | Estimated Charge: \$11.57 |
| Service Type: FedEx Standard Overnight® | Shipper Account #: 060529310 |
| Package Type: FedEx® Envelope | |
| Tracking Number(s): 787180109733 | |
| From Address: Northwestern Memorial HealthCare BRIDGET ORTH 211 E Ontario St Suite 1750 Chicago, IL 60611 312-926-8650 | To Address: Senate District 29 Senator Julie Morrison 700 Osterman Avenue DEERFIELD, IL 60015 3129268650 |

July 13, 2017

Representative Scott Drury
District 58
425 Sheridan Road
Highwood, IL 60040

RE: *Notice of Discontinuation*
Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital

Dear Representative Drury:

Northwestern Medicine Lake Forest Hospital (LFH) is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending Health Facilities and Services Review Board approval.

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Patients and families have been notified of our plan for closure. We have developed formal relationships with five facilities to accept transfers from LFH. These five facilities collectively have hundreds of beds to accommodate LFH patients. Since the announcement of our proposed discontinuation, other area facilities have reached out to offer their available beds as well.

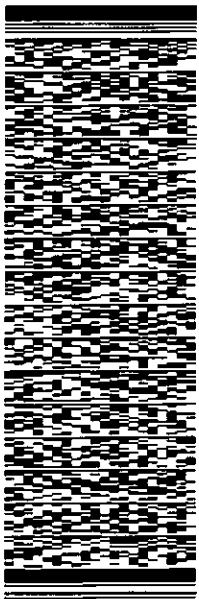

Please feel free to contact Rob Christie with any questions at 312-926-7527 or rchristi@nm.org.

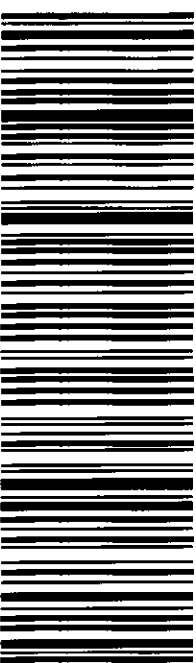
Sincerely,



Bridget S. Orth
Regulatory Planning

| | | |
|---|--|--|
| ORIGIN ID: CHIA (312) 926-8650 BRIDGET ORTH NORTHWESTERN MEMORIAL HEALTHCARE 211 E ONTARIO ST SUITE 1750 CHICAGO, IL 60611 UNITED STATES US | | SHIP DATE: 13 JUL 17 ACTWGT: 9.50 LB CAD: 10925/817MSX3100 |
| TO REPRESENTATIVE SCOTT DRURY HOUSE DISTRICT 58 425 SHERIDAN ROAD HIGHWOOD IL 60040 (312) 926-8650 REF: | | BILL THIRD PARTY |
| PO DEPT 1057 | | 546J1/C0C2/53C1 |

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|  |  |
| REL# 3785346 | J17111782149117 |

| | |
|---|---|
| TRK# 7871 8015 7106 0201 | FRI - 14 JUL 3:00P STANDARD OVERNIGHT |
| 79 OBKA IL-US 60040 ORD |  |

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1. Fold the first printed page in half and use as the shipping label.
2. Place label in shipping pouch and affix it to your shipment so that the barcode portion of the label can be read and scanned.

Shipment Summary

| | |
|--|---|
| Ship Date: 7/13/2017 Service Type: FedEx Standard Overnight® Package Type: FedEx® Envelope Tracking Number(s): 787180157106 From Address: Northwestern Memorial HealthCare BRIDGET ORTH 211 E Ontario St Suite 1750 Chicago, IL 60611 312-926-8650 | Estimated Charge: \$11.57 Shipper Account #: 060529310 To Address: House District 58 Representative Scott Drury 425 Sheridan Road HIGHWOOD, IL 60040 3129268650 |
|--|---|

July 13, 2017

Karen Senger
Illinois Department of Public Health
Health Care Facility & Programs
525 W Jefferson Street 4th floor
Springfield, IL 62761-5058

RE: *Notice of Discontinuation*
Long Term Care Category of Service
Northwestern Medicine Lake Forest Hospital

Dear Ms. Senger:

Northwestern Medicine Lake Forest Hospital is preparing a Certificate of Exemption application addressing the discontinuation of its 84-bed long-term care category of service. The beds are located in the Westmoreland Nursing Center, connected to the current hospital located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur by the end of the calendar year, pending HFSRB approval.

In preparation for the completion of the new Northwestern Medicine Lake Forest Hospital, we engaged in an extensive planning process to determine how to best advance our facilities and campus to serve the healthcare needs of the community. Through this process, we have determined that the required financial resources and regulatory process to maintain an independent custodial care facility on the Lake Forest Hospital Campus, once the hospital relocates to its new location, is no longer a feasible option.

Patients and families have been notified of our plan for closure. We have developed formal relationships with five facilities to accept transfers from LFH. These five facilities collectively have hundreds of beds to accommodate LFH patients. Since the announcement of our proposed discontinuation, other area facilities have reached out to offer their available beds as well.

Please feel free to contact me with any questions at 312-926-8650 or borth@nm.org.

Sincerely,



Bridget S. Orth
Regulatory Planning

| | | | |
|---|--|--|---|
| TO KAREN SENGGER IDPH 525 W JEFFERSON ST, 4TH FLOOR SPRINGFIELD IL 62761 INV (312) 926-8650 REF PO DEPT 1067 | | ORIGIN: CHIA (312) 926-8650 BRIDGET ORTH NORTHWESTERN MEMORIAL HEALTHCARE 211 E ONTARIO ST SUITE 1750 CHICAGO, IL 60611 UNITED STATES US | SHIP DATE: 13 JUL 17 ACTWGT: 0.50 LB CAD: 109257817WMSX3100 BILL THIRD PARTY |
|   J171117821481ur | | REL# 3785346 | |
| TRK# 7871 7991 5807 [0201] | | FRI - 14 JUL 3:00P STANDARD OVERNIGHT | |
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| From Address: Northwestern Memorial HealthCare BRIDGET ORTH 211 E Ontario St Suite 1750 Chicago, IL 60611 312-926-8650 | To Address: IDPH Karen Senger 525 W Jefferson St, 4th floor SPRINGFIELD, IL 62761 3129268650 |

SECTION IX. SAFETY NET IMPACT STATEMENT

- 1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible to have such knowledge.**

LFH believes there is an abundant supply of long term care beds in Lake County. Given the calculated excess of 326 beds and LFH's low census, this project will not have a material impact of any safety net services in the community.

- 2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services.**

For the reasons stated above, LFH believes that this project will not have a negative impact on any other provider or any safety net services.

- 3. How the discontinuation might impact the remaining safety net providers in a giving community, if reasonably known.**

LFH believes that this discontinuation will have a positive impact on the remaining providers of long-term care services in Lake County by reducing the excess beds in the planning area and increasing the utilization at other long-term care facilities.

Charity Care and Medicaid

LFH shares Northwestern Memorial HealthCare's commitment to provide care for those unable to pay, consistently providing the highest percentage of charity care as a percent of patient revenue among Lake County hospitals.

In 2015, LFH provided 29.9% of the total charity care in Lake County, the highest percentage of any hospital located in the county.

| Safety Net Information per PA 96-0031 | | | |
|--|---------------------|----------------------|----------------------|
| CHARITY CARE | | | |
| Charity (# of patients) | FY14 | FY15 | FY16 |
| Inpatient | 130 | 142 | 230 |
| Outpatient | 2,002 | 1,815 | 4,228 |
| Total | 2,132 | 1,957 | 4,458 |
| Charity (cost in dollars) | | | |
| Inpatient | \$ 2,832,383 | \$ 2,825,621 | \$ 2,163,370 |
| Outpatient | \$ 6,601,617 | \$ 6,087,877 | \$ 5,797,119 |
| Total | \$ 9,434,000 | \$ 8,913,498 | \$ 7,960,489 |
| MEDICAID | | | |
| Medicaid (# of patients) | FY14 | FY15 | FY16 |
| Inpatient | 469 | 444 | 662 |
| Outpatient | 15,747 | 18,746 | 18,028 |
| Total | 16,216 | 19,109 | 18,690 |
| Medicaid (revenue) | | | |
| Inpatient | \$ 6,527,610 | \$ 4,765,038 | \$ 3,760,785 |
| Outpatient | \$ 2,653,230 | \$ 6,119,666 | \$ 8,825,975 |
| Total | \$ 9,180,840 | \$ 10,884,704 | \$ 12,586,760 |

Source: IDPH Annual Hospital Questionnaires

LFH Community Benefit

To help meet the needs of the community during FY16, LFH contributed \$50.2 million in community benefits, including \$7.96 million in charity care alone. Other elements of our community benefit contribution are:

- \$35.4 million Government sponsored care (unreimbursed cost of Medicaid and Medicare).
- \$1.3 million other community benefits: LFH provides community benefit through subsidized health services including education and information to improve the health of the community; donations to charitable and community organizations; volunteer efforts; language assistance and translation services for patients and their families; and more.
- \$5.5 million Bad Debt (based on cost): An important part of LFH's commitment to providing quality and accessible healthcare includes covering the expense of payments that were expected but not received.

Other LFH Community Benefit Activities

Through charity care, outreach services and health education programs, LFH improves access to healthcare services and responds to the priority health needs of the residents of Lake County, especially among the uninsured or underinsured. Examples include:

- LFH and NMHC helped to organize and fund the development of Erie HealthReach Waukegan Health Center (EHWHC), which opened in 2014 in response to the critical need for primary care services for the uninsured, estimated at more than 75,000 Lake County residents at that time. EHWHC has vastly expanded access to primary care for those with no insurance or those unable to pay for healthcare in Lake County. The site serves as a patient-centered medical home, providing primary, preventative, and dental care. Health education and chronic disease self-management programs established at other Erie sites have been successfully replicated at the Lake County facility. EHWHC patients are referred to LFH for medically necessary services and in FY16, almost 1,400 patients received diagnostic and specialty care at LFH under this arrangement.
- Launched in 2015, LFH welcomed its second class of residents from the Northwestern McGaw Family Medicine Residency program in FY16 and serves as the program's home site. The residents train in clinical practice providing care at EHWHC. Through this program, the medical residents significantly expand the primary care physician resources available at Erie and thus in Lake County.
- To meet the needs of the community, in fiscal year 2016 LFH's medical staff added a physician specializing in psychiatry as well as a clinically licensed social worker. These additions significantly expand access to psychiatry and behavioral health services in Lake County.
- LFH maintains Level II Trauma Center designation. This requires LFH to maintain the necessary equipment and resources, including a full range of specialists and heliport, in order to provide the next highest level of surgical care and to work in collaboration with a Level I center.
- Staff at LFH work closely with the Lake County Department of Health and area school districts to address priority health needs of the community, including recent efforts to address high school-age substance abuse and suicide and expanding programs to promote an active, healthy lifestyles among residents of Lake County.
- LFH staff provide medical career advisory training at Lake County High School's technical campus and assist students and parents in exploring educational paths to support career goals.
- The LFH volunteer services department collaborates with area high schools on their Transition Student Volunteer Initiative. This initiative matches special education students with volunteer positions to build the students' job skills in preparation for entering the workforce. In FY16, three students were involved in the initiative where they held various positions at LFH and the Lake Forest Health and Fitness Center.
- In FY16, more than 65 LFH employees and their families participated in a day of service at Lambs Farm, a not-for-profit organization that provides residence, vocational services, employment, and support to adults with developmental disabilities in Lake County. The volunteers helped with painting and landscaping services.

X. CHARITY CARE INFORMATION

LFH is committed to providing care for those who are unable to pay, consistently providing the highest percentage of charity care as a percent of patient revenue among Lake County hospitals.

In 2015, LFH provided 29.9% of the total charity care in Lake County, the highest percentage of any hospital located in the county.

Lake Forest Hospital

| | FY14 | FY15 | FY16 |
|----------------------------------|----------------|----------------|----------------|
| Net Patient Revenue | \$ 220,724,861 | \$ 253,644,169 | \$ 270,008,793 |
| Amount of Charity Care (charges) | \$ 44,462,998 | \$ 44,149,376 | \$ 37,682,712 |
| Cost of Charity Care | \$ 9,434,000 | \$ 8,913,498 | \$ 7,960,489 |

Northwestern Memorial HealthCare

| | FY14 | FY15 | FY16 |
|----------------------------------|-----------------|-----------------|-----------------|
| Net Patient Revenue | \$2,296,846,000 | \$3,702,986,000 | \$4,081,581,000 |
| Amount of Charity Care (charges) | \$ 304,890,000 | \$ 418,054,000 | \$ 386,070,000 |
| Cost of Charity Care | \$ 66,747,000 | \$ 81,601,000 | \$ 80,459,000 |

Note: numbers do not reflect the impact on acquisitions/affiliations for periods prior to the acquisition/affiliation.

During FY16, Northwestern Memorial HealthCare contributed \$747.4 million in community benefits including charity care, other unreimbursed care, research, education, language assistance, donations and other community benefits.